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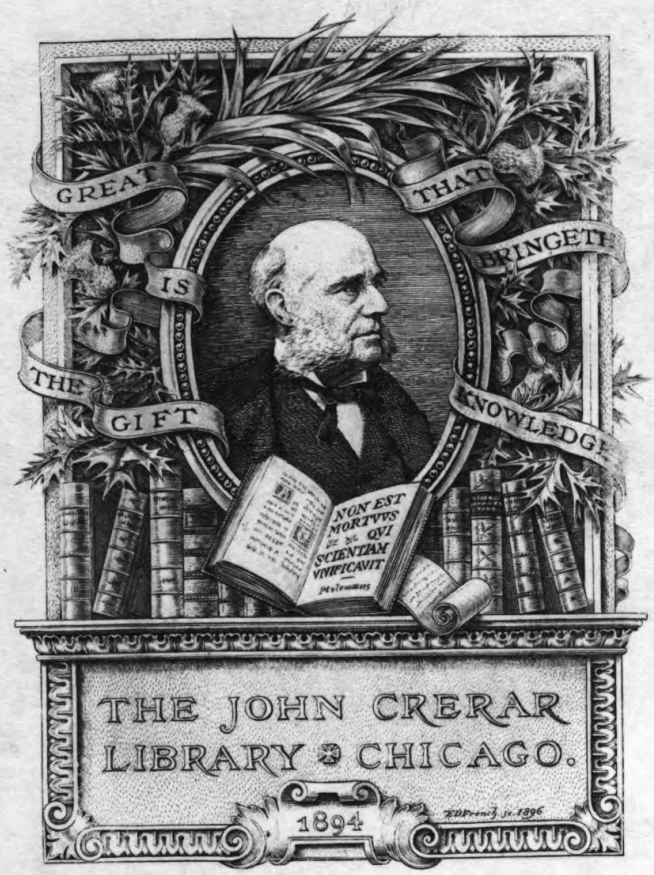
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1894

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY

OF

LONDON.

VOL. VI.

1898–99.

WITH

LISTS OF OFFICERS, LIST OF MEMBERS, ETC.

LONDON:
PRINTED BY ADLARD AND SON,
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1899.

OFFICERS AND COUNCIL

OF THE

Laryngological Society of London

ELECTED AT

THE ANNUAL GENERAL MEETING,

JANUARY 6TH, 1899.

President.

F. DE HAVILLAND HALL, M.D.

Vice-Presidents.

A. BRONNER, M.D.

W. R. H. STEWART, F.R.C.S. (Edin.)

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Librarian.

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Secretaries.

WILLIAM HILL, M.D., B.Sc.

H. LAMBERT LACK, M.D., F.R.C.S.

Council.

EDWARD LAW, M.D.

WALTER SPENCER, M.S.

F. W. MILLIGAN, M.D.

A. A. BOWLBY, F.R.C.S.

HERBERT TILLEY, F.R.C.S.

PRESIDENTS OF THE SOCIETY.

(From its Formation.)

ELECTED	
1893	Sir George Johnson, M.D., F.R.S.
1894–6	Sir Felix Semon, M.D., F.R.C.P.
1897–8	H. Trentham Butlin, F.R.C.S.
1899	F. de Havilland Hall, M.D., F.R.C.P.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ORDINARY MEETING, *November 4th*, 1898.

HENRY T. BUTLIN, Esq., F.R.C.S., President, in the Chair.

HERBERT TILLEY, M.D., WILLIAM HILL, M.D., } Secretaries.

Present—36 members and 3 visitors.

The minutes of the previous meeting were read and confirmed.

The following gentlemen were elected members of the Society:

F. J. Dixon, M.B., B.C., Welbeck Street, W.
Frederick Spicer, M.D., Devonshire Street, W.

LUPUS OF THE LARYNX (WITH MICROSCOPICAL SECTIONS AND DRAWINGS FROM A CASE).

Shown by Professor FERDINAND MASSEI, Naples (Honorary Fellow of the Society). A girl æt. 10 was seen last year by Professor Massei suffering from typical lupus of the larynx. A year previous the case had been sent to him as one of syphilis, the cutaneous manifestations having been diagnosed as such by a competent dermatologist. In spite of energetic antisyphilitic treatment matters underwent no amelioration, and whatever change took place was for the worse. Professor Massei then decided that the affection of the larynx was lupus, and the cutaneous appearances confirmed this diagnosis. The lungs were normal. Sections of tissue removed from the epiglottis showed giant-cells around which were disposed

epithelioid cells in the manner characteristic of tubercle. Inoculations of guinea-pigs were, however, unfruitful, but recently the patient presented symptoms of pulmonary phthisis.

He proposes to do away with the distinction between tuberculosis and lupus, holding that they are identical, as shown in this case by the microscopical appearances and the recent development of consumption. The negative result of inoculation is not, in his opinion, a disproof, because it goes along with the extreme scantiness of the bacilli in lupus tissue, which is so well recognised.

(Professor Massei has presented to the Society the sections from this case, and they may be seen on application to the Librarian.)

Mr. Wyatt Wingrave thought that the non-differentially stained specimen presented by Professor Massei was hardly sufficient evidence of the pathological identity of lupus and tubercle; and since there was much difference of opinion as to their respective histological details, a demonstration of bacilli would have proved of great interest and importance.

Sir Felix Semon said that he thought it was generally agreed that lupus and tubercle were essentially the same, but that the former was characterised by its chronic course and the paucity of tubercle bacilli, whereas comparatively opposite conditions held in tubercle.

Man aged 51 with Hypertrophic Laryngitis of Doubtful Nature.

Shown by Dr. StClair Thomson. The patient, J. H—, æt. 51, had been hoarse for eight months. There was no specific history; the lung-sounds were normal; and the patient confessed to having taken very freely of alcohol. He has been under iodide of potassium for over a month without any improvement. There is an irregular growth on the right processus vocalis; the right cord is decidedly impaired in its movement. There is thickening of the opposite (left) processus vocalis and general hypertrophic laryngitis. No glands are to be felt. The patient has not lost flesh. There is a good deal of chronic rhinitis.

Sir Felix Semon was not certain that the case was simply hypertrophic laryngitis; there was some defective mobility of the right vocal cord, and a small excrescence on the vocal process.

This suggestion of malignancy was also endorsed by Dr. Bond, who thought that the absence of any intervals of improvement (which were frequent in simple chronic laryngitis) rather favoured the idea of grave disease.

Mr. LAKE had seen the patient some time before, and on account of the rapid loss of weight and suspicious appearance had suggested exploratory laryngo-fissure.

Dr. STCLAIR THOMSON proposed to remove a portion of the growth from the right processus vocalis, and report to the Society as to its microscopical characters.

EPITHELIOMA OF LARYNX.

Shown by Dr. BARCLAY BARON (Bristol). Patient male æt. 64. About twelve months ago he found him suffering from extensive growth affecting the front parts of both vocal cords, especially the right and the anterior commissure. This was removed at several sittings by means of forceps and curette. The growths were multiple, not ulcerated, and there was no redness or swelling of surrounding structures, and the case was regarded as probably a non-malignant one. Some months ago he again came to the hospital, and the whole larynx was filled with warty growth, with redness and swelling of the right ventricular band. This was removed by a surgical colleague after thyrotomy, and proved to be epithelioma, and it has extensively recurred since the operation last June. Dr. Baron queried if this is not a case of transference of a benign into a malignant growth.

Sir FELIX SEMON rather questioned whether the papillomatous nature of the growth in the first instance was not more apparent than real. The warty appearance might be merely superficial, the separate papillomata growing from a common base. The man's age, again, was not in favour of a benign growth. Under all circumstances he thought the supposed transformation could not be classified otherwise than "extremely doubtful." He himself had hardly any doubt that the disease was malignant from the first.

SARCOMA OF NOSE.

Dr. BARON also showed a case of growth in the right nostril of a woman æt. 34 years. Three months ago she found some epiphora; an attempt was made to pass a probe through the lachrymal duct by her medical adviser, but he was unable to reach the nose. Since then there has been much pain over the eyebrow and roof of nose, some discharge from the nostril, and a gradual obstruction of it. She was seen in consultation, and the whole nostril found to be filled with a greyish growth which projected into the naso-pharynx. It bled freely

on probing, and removal of a piece with a snare caused very free hæmorrhage. She also said that she had bled freely three times in a fortnight. There was a soft elastic swelling at the inner angle of the eye. Microscopically the growth appeared to be a mass of round cells, and the clinical history and appearance were believed to point to sarcoma.

Mr. SPENCER did not think that there were definite evidences of sarcoma present. The mass of granulations bathed in muco-pus might have an inflammatory origin, *e. g.* be gummatous, or have arisen in one of the sinuses. He advised that the nose should be first of all cleared out by curetting under an anæsthetic with the head hanging low, and then be plugged. In a day or two, on the removal of the plug, it would be possible to examine the interior of the nose and naso-pharynx completely. The subsequent course of the case would then enable a diagnosis to be made.

The PRESIDENT agreed entirely with Mr. Spencer as to the course of treatment he had suggested, and thought the mass had more the appearance of a benign than a malignant growth. He thought it would be very difficult to differentiate microscopically between a chronic inflammatory mass of this kind and a small round-celled sarcoma.

Mr. WAGGETT thought the microscopic specimen could not be distinguished from a mass of granulation tissue.

Dr. HILL had a similar case under his care eight years ago; as the pathological report declared a portion removed for microscopy to be undoubtedly malignant, he handed the case over to Mr. Page, who cleared the nose out by Rouge's operation. Slight recurrence took place from time to time, but the patient was still living and well, and the speaker had long ago been compelled to recognise that the case was really one of granulomatous growth associated with suppuration from the sinuses.

Mr. ROBINSON thought that there was a possibility of the lesion being tuberculous, the nose becoming infected subsequent to the injury. The crusted, dry appearance, and its localisation to one cavity, did not seem to favour the view of its sarcomatous nature.

The PRESIDENT thought that the smoothness of the swelling outside, and the ulceration inside, seemed to point more to an infective disease than to a new growth.

NASAL CASE FOR DIAGNOSIS.

Dr. BARON also showed a young man who had a blow on the nose six months ago. Three weeks afterwards he noticed a swelling on the outside of the nose, and this has increased steadily. It is red and hard, and presents no fluctuation. There was no discharge until

about three weeks ago, when some pus came from the nostril, and Mr. Morton, under whose care the case was admitted at the Bristol General Hospital, took away a piece of necrosed cartilage. There is no history of syphilis, but he has taken antisyphilitic doses of iodide of potash for a month or so with no effect. There is some history of tubercle in the family, but the man is quite healthy excepting for the nose trouble.

The case was shown to get the opinion of the members as to the nature of the swelling, Dr. Baron believing it to be inflammatory, with necrosis and sequestrum of cartilage as the cause of it.

Cancer of Œsophagus with Paralysis of one Vocal Cord.

Shown by Dr. Watson Williams. W. D—, male, æt. 64, complained July 1st, 1898, of difficulty in swallowing, but early in the previous January he had noticed some difficulty in swallowing a piece of meat, which had increased gradually until he could only swallow soft food. He lost flesh considerably—nearly three stone in weight. In August, 1897, his voice had become slightly thickened and hoarse, and remained so since.

Laryngoscopic examination showed the right vocal cord in the cadaveric position, and pointed to a right recurrent nerve paralysis. There was no obvious cause for this, neither were physical signs in the chest indicative of organic lesions found. A No. 20 œsophageal bougie was easily passed into the stomach. No history of syphilis. Rest in bed and small doses of iodide of potash were followed by rapid improvement in swallowing powers and in his general health.

In five weeks' time marked inspiratory dyspnœa developed, increasing so rapidly that a low tracheotomy was performed with relief. He now expectorated quantities of mucus, and, rapidly sinking, died four days after the operation.

Post-mortem examination disclosed a circular perforation in the trachea two inches above the bifurcation, three quarters of an inch in diameter, and communicating with the gullet. The right posticus muscle was atrophied. The anterior gullet wall was invaded by an epitheliomatous growth, which involved also a post-tracheal gland. The right recurrent laryngeal nerve was involved in the growth and compressed. Old caseating tubercular deposits were found in both pulmonary apices, and the bases were affected with septic pneumonia.

Dr. Williams pointed out that the value of recurrent paralysis as a symptom of malignant disease of the gullet depends much on the presence or absence of signs of organic disease in the chest cavity, which might also produce a similar paralysis. The early improvement under treatment in this case certainly might have at first suggested a thoracic aneurysm. It is worthy of note that the right cord was probably paralysed five months before he suffered from dysphagia.

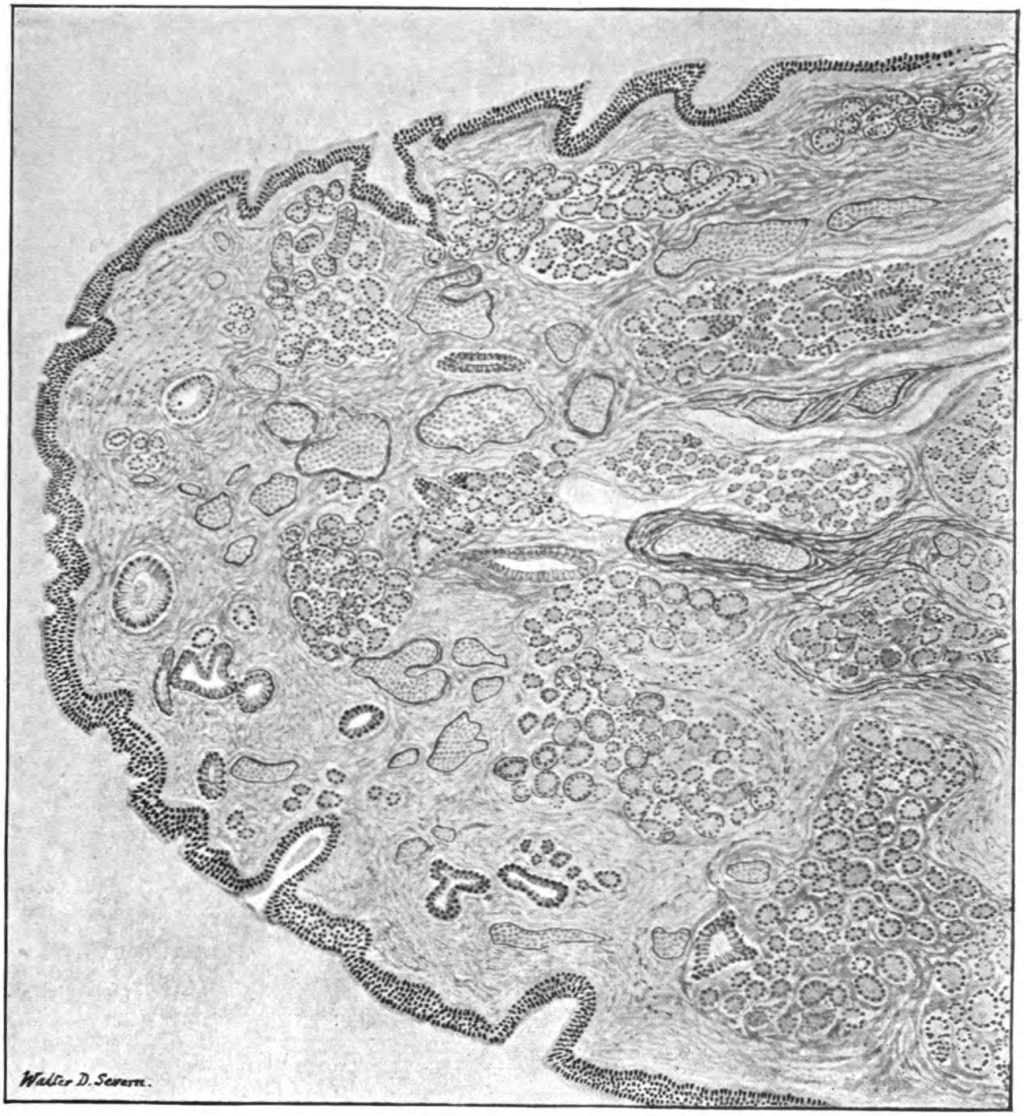
Sir FELIX SEMON thought that in all cases where a patient died with paralysis of a vocal cord the laryngeal muscles should be carefully examined for varying degrees of degenerative changes, so that we might gain further and more exact information as to the question whether in organic progressive disease of the recurrent laryngeal nerve the abductor muscle was the first to succumb. Dr. Friedrich's descriptions of such cases had been most valuable.

A CASE OF PAROXYSMAL SNEEZING ASSOCIATED WITH GREAT HYPERTROPHY OF TISSUES IN NEIGHBOURHOOD OF THE SEPTAL TUBERCLE (SHOWN AT JUNE MEETING).

Shown by Mr. ARTHUR CHEATLE. A man complained of nasal obstruction and violent attacks of sneezing. On the right side a pink soft mass, springing from the septum opposite the middle turbinal, extending downwards and forwards, having a broad base with slightly overhanging lower edge, quite obscured the middle meatus and reached down to the inferior turbinal. The same condition existed on the left side, but to a much less degree, the mass being pale.

With a cold snare a large portion of the mass on the right side was removed. Sections showed great hypertrophy of the normal tissue; numerous glands, giving an almost adenomatous appearance with large blood-spaces, and great increase of connective tissue.

Dr. PEGLER thought one would be scarcely justified in designating this case an adenoma of the septum, because, although the microscopic sections displayed an abundance of racemose glands, this was a common condition in mucous membrane hypoplasiæ of the septum and turbinals.



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MR. ARTHUR CHEATLE'S CASE.

Growth in Anterior Commissure has been Removed, but Paresis of Right Cord remains (Patient shown at March Meeting).

Shown by Dr. Pegler. The small commissural fibroma of left cord was removed with forceps six months ago, *i. e.* immediately after patient was shown to the Society.

All trace of the growth has now disappeared, but the abductor paresis of the opposite (right) cord remains unchanged.

The voice is much improved.

Case of Large Angioma of Larynx.

Shown by Dr. Bond. Patient male æt. 55. When a boy he used to shout tremendously. He has had hoarseness for about twenty-eight years; some twenty years ago he was under Sir M. Mackenzie, who found and treated the tumour in larynx. Since then the patient has occasionally attended at Golden Square. An account of the case was published by Dr. Wolfenden in 1888 in the 'Journal of Laryngology.' At various intervals patient has spat up blood, and when seen by me in March last was coughing up blood and phlegm freely.

He has a dark bluish tumour on right ventricular band, covering quite two thirds of it; there is a separate little offshoot above, and a third one on left ventricular band in front. The cords are apparently free.

Patient says that he used to be treated weekly with the galvano-cautery. It is a question, considering the severe hæmorrhage last March, whether one should not do a more radical operation, and the opinion of the Society on this point was desired.

Mr. Spencer supported the proposal of Dr. Bond to perform thyrotomy and freely excise the disease. He noted that the cord on the right side moved very little, and there was a small glandular enlargement in front of the carotid on that side. It was possible that the growth was tending to show malignant characters.

The President concurred with the suggestion of surgical interference.

? Epithelioma of Larynx.

Shown by Mr. Steward for Mr. Symonds. D. H—, æt. 55, attended at Guy's Hospital on August 5th, 1898, for partial loss of voice and pain in the throat and below the right ear. The loss of voice began in December, 1897, after an attack of influenza, and since that time has been gradually increasing. Examination showed an irregular thickening of the right vocal cord, which, however, was distinctly moveable. Iodide of potassium was prescribed. A fortnight later the right cord was found to be fixed, and some irregularity of the false cord was noticed.

On September 23rd the growth was distinctly larger, and some blood had been coughed up. A small piece of growth was removed, and reported, after examination by the pathologist, to be inflammatory. After this some improvement in symptoms took place, for on October 23rd the patient reported that he was free from pain, and that he could speak with less effort. There was, however, no change in the laryngoscopic appearances.

Drs. Spicer and Grant thought the case was malignant.

Sir Felix Semon could not, however, satisfy himself that the ulceration described by the first speaker was at all obvious.

Large Lipoma of Soft Palate.

Shown by Dr. Bond. Patient is a female æt. 49. She has a large semi-fluctuating tumour in soft palate on right side, extending on left beyond mid-line and on the right behind angle of jaw. Eight years ago he removed a large, many-lobed fatty tumour through external incision in parotid region. The mass removed weighed several ounces. The operation was followed by right facial paralysis, from which patient has almost recovered.

The original tumour was a parotid one; the present one has probably developed from some fragment left.

Six years ago her right breast was removed in one of the London hospitals.

The President thought that it would be possible to remove the tumour of the palate, which might easily shell out through a fair incision.

Tubercular Laryngitis after Removal of Large Inter-arytænoid Mass.

Shown by Mr. Lake. The patient, a girl of 21, had been under treatment for eight months. When first seen she had bilateral ulceration of the vocal cords, great bilateral swelling of the arytænoid cartilages, and a very large interarytænoid mass. The arytænoids were treated by double curettage in April, and had not been enlarged since, and the cords were quite healed. The mass removed from the inter-arytænoid fold was shown, as also were Mr. Lake's forceps for the removal of such growths.

Dr. Herbert Tilley thought that Mr. Lake was not only to be congratulated on the excellent result attained in this case, but also for bringing the instruments to such perfection and making it a comparatively easy task to deal with such cases of tubercular laryngitis. He has seen great relief afforded patients by removal of these œdematous masses, and had no doubt that they would see many more in the immediate future.

A Case of Membranous Laryngitis.

Shown by Mr. Lake. The patient, a man æt. 25, was the subject of a laryngitis of combined tubercular and syphilitic origin. He had loss of voice of eight weeks' duration. On October 17th a white membrane was noticed on the posterior surface of the epiglottis, which had recurred after removal.

In reply to Dr. Thomson, Mr. Lake said that no bacteriological examination had yet been made, but a further report was promised.

Paresis of the Right Facial Nerve and of the Right Side of the Palate following Tympanic Suppuration.

Dr. William Hill showed a female æt. 24 exhibiting this unusual condition. Right tympanic suppuration followed measles eight years ago; a polypus was removed about four years later, and after this operation the right side of the face was said to be "drawn up;" two years ago, however, this side "got weak," and the face was drawn up on the opposite side. For a year she has experienced some difficulty in swallowing, especially solids, though fluids have occasionally passed into the naso-pharynx; she has continuously "felt a lump" in her throat.

There is now, in addition to facial paresis, marked asymmetry of the palate, the arch being much higher on the left side; the right is flaccid, and the uvula is adherent to this side. The reflex, which is very active on the left side, appears to be absent on the right. There is reaction of degeneration in the right facial nerve, but for want of a suitable electrode this test has not yet been applied to the palate.

The view that the palate was partly supplied by the facial through the vidian and large superficial petrosal nerves has been taught by anatomists since the time of Sir Charles Bell down to the present decade; but neurologists have for several years, on clinical and experimental grounds, combated this teaching, pointing out that the true motor supply of the palate is from the medullary fibres of the spinal accessory. The case was therefore of great neurological interest, few reliable cases having been recorded, and it was desirable to ascertain the views of the members as to whether the asymmetry of the palate was actually due to motor paresis (and not to an acquired or congenital deformity); and if so, the further question had to be faced, whether the paresis of the facial muscles and of the palate were due to a common lesion within the temporal bone rather than representing an accidental association.

Dr. Dundas Grant was of the opinion that the median position of the dimple in the palate during phonation was a strong argument against the diagnosis of hemiplegia of the larynx. He considered the appearance, apart from the phonation, as inconclusive, and was inclined to think that the asymmetry then present was due to inflammatory changes in the pillars of the fauces, and not to nerve lesion.

Frontal Sinusitis.

Dr. Hill also showed a male æt. 40, on whom he had recently operated for chronic suppuration of the frontal sinus by the Ogston-Luc method. The chief points of practical interest in the case were: (1) the shortness of the skin incision along the brow; (2) the perfect æsthetic effect, as the scar was barely visible, and the previous displacement outwards of the eye had disappeared; (3) no drainage-tube was employed.

Dr. Herbert Tilley, in reply to a question as to what instrument was used to make a free passage into the nose, said that he had found a Krause's antrum trocar fulfil the object very well, the slight curve on the instrument being just that which was necessary.

Case of (?) Œsophageal Pouch.

Shown by Mr. Cresswell Baber. F. G—, a butler, æt. 62. First seen at the Brighton Throat and Ear Hospital on October 24th, 1898. For over a year he had had a peculiar sensation in his throat as if his uvula were too long, and he brought up a quantity of phlegm. Seven or eight months ago he first noticed that he returned lumps of undigested meat which had been taken the day before. This usually happens in the morning after breakfast, when they return together with fragments of that meal. There is no marked difficulty in swallowing, but occasionally he has to make two efforts before the act can be accomplished. Solids are more troublesome to swallow than liquids. He feels satisfied after a meal, and is conscious that he swallows most of the meal without any difficulty. No vomiting or pain. He has a "croaking" or gurgling noise in his throat, especially when lying down and at meals, which is followed by the bringing up of quantities of phlegm. He often has to leave the table because of the discomfort.

On examination the pharynx is irritable and congested, and uvula thick. Larynx congested, especially the cords; otherwise it is normal. Much white frothy secretion is seen coming up behind the arytænoids. External examination shows a doubtful fulness in the left posterior inferior triangle of the neck, but I have not examined him after a full meal. Pressure with the fingers above the clavicles, especially at the left side, produces a gurgling noise, and escape of gas by the mouth; and after he has swallowed some milk and bread, pressure in this region causes it immediately to return. Liquid taken alone is partly returned when he stoops sharply forward. Patient is well nourished, and has not lost flesh to any extent. His weight, which on July 26th, 1898, was 12 st. 9½ lbs., and on August 30th 12 st. 13 lbs., is now (October 31st) 12 st. 11 lbs. I have passed two large-size elastic bougies down, and they both became arrested about nine inches past the teeth. The ends could not be distinctly felt in the left posterior inferior triangle. Chest normal, except a narrow patch with slightly impaired resonance under the left clavicle.

Dr. StClair Thomson suggested that the case afforded a useful field for the employment of the Röntgen rays. He had not himself had such a case, but it had occurred to him that if two metallic bougies were passed down the œsophagus, one into the pouch and

the other into the stomach, and if an X-ray photograph were then taken of the neck and chest, we might get very useful information as to the situation and relationship of this pouch.

The PRESIDENT said that before operating to remove the pouch the patient should be carefully examined in order to ensure he was in a fit state of health, and that it should be clearly ascertained that there was no organic stricture of the œsophagus, a probe passing easily into the stomach as well as into the pouch.

AN EXCEPTIONAL CASE OF CLEFT PALATE.

Shown by Mr. MORLEY AGAR. The bony cleft was on the left side, and only showed the inferior turbinate in its whole length. There was also some deformity of the vomer.

Mr. ROBINSON was of opinion that this deformity was not very unusual. He explained it as a complete cleft from front to back, but to the left side of the mid-line, so that there was non-union on the left side of the maxilla to the pre-maxilla, and of the palatal processes of maxilla and palate to their fellows on the right side. The appearance posteriorly was due to the dragging well to the right of the soft palate and the sloping edge of the bones, and the right posterior choana thus coming into view.

NOTES OF A CASE OF ULCERATION OF THE SOFT PALATE.

Shown by Mr. PARKER. A. G—, male, æt. 32. Last Easter his throat became very sore—was said to be ulcerated. After ten weeks' treatment it got quite well, and remained so till a few days ago. He has always been a strong healthy man, and denies all history of syphilis. He had gonorrhœa thirteen years ago. He is married and has three healthy children, but he states that his wife has had two or three miscarriages.

On examination the soft palate and uvula are found to be covered with a ragged, straggling ulceration of a superficial character; between the patches of ulceration there is a peculiar nodular appearance, and there is a small areola of redness round the diseased parts.

The diagnosis lies between tertiary syphilis and tuberculosis. The former seems to be more probable.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ORDINARY MEETING, *December 2nd*, 1898.

F. DE HAVILLAND HALL, M.D., Vice-President, in the Chair.

HERBERT TILLEY, M.D., }
WILLIAM HILL, M.D., } Secretaries.

Present—37 members and 10 visitors.

The minutes of the previous meeting were read and confirmed.

The following gentleman was nominated for election at the next meeting:

H. St.George Reid, 25, Old Burlington Street, W.

REPORT OF THE MORBID GROWTHS COMMITTEE.

Slide L.S.L. 16.—Section of growth removed from a female patient of Dr. Barclay Baron's, shown at meeting November 4th, 1898. The Committee report that the specimen submitted to them contains a mass of large polyhedral embryonic cells, which some would term an alveolar sarcoma, others spheroidal-celled carcinoma. Some of these cells are in an active stage of proliferation. The arrangement of the cells tends to show some trace of alveolation, and it is noticeable that there is an intra-cellular fibrous structure. In deeper portions of the section there are evidences of inflammatory change, some recent and some of longer standing. Blood spaces are seen without definite walls. In our opinion the growth belongs to a class which behaves in many respects like sarcoma, but showing slight and local malignancy.

Slide L.S.L. 17.—Sections of glands under sterno-mastoid to-

gether with portion of internal jugular vein, removed from patient shown by Dr. Bond May 13th, 1896, p. 86; November 11th, 1896, p. 4. Report on section January 13th, 1897, p. 40. Case "Sarcoma of Nose."

The Committee regret that owing to some mistake in the constitution of the fluid in which the growth was originally placed, the mass had almost decomposed before they received it, and only one small portion was at all suitable for sections. This portion was undoubtedly of malignant nature, but whether it was a spheroidal-celled carcinoma or an alveolar sarcoma the condition of the section rendered it impossible to decide.

Wall Charts for Teaching Signs of Suppuration in the Nasal Sinuses.

Shown by Dr. Dundas Grant. These charts were drawn up by Dr. Grant to illustrate his lectures in June, 1898, and were founded mainly, but with various modifications, on the classifications of signs as *presumptive, probable,* and *certain,* given by Lermoyez in his work on the treatment of diseases of the nose and sinuses of the face.

Section of Cyst removed from the Naso-pharynx.

Shown by Mr. Arthur Cheatle. A man æt. 19 came to the Royal Ear Hospital complaining of nasal obstruction. Besides some turbinal hypertrophy and a spur in the nose, a smooth pink mass, the size of half a walnut, was seen in the naso-pharynx immediately behind the septum and stretching from one Rosenmüller's fossa to the other. Under chloroform it felt tense, and was ruptured with the finger-nail before removal. A microscopical section through the mass showed a large and a small cyst, each lined with columnar ciliated epithelium, with a slight amount of adenoid tissue outside on the cut surface.

Preparations of Hypertrophied Tonsils.

Mr. Wyatt Wingrave exhibited sections of enlarged tonsils for inspection by the naked eye. They illustrated the conditions of simple hypertrophy unattended with any inflammatory changes.

The points of chief interest were the scantiness of the connective-tissue elements, the depth of the lacunæ, which reached to the "bed" of the tonsil, and the fact that one aperture was common to several lacunæ.

The tonsils before cutting had been soaked in collodion, which method binds the tissues together and prevents the lymph follicles falling out.

Sections of Lupus of Larynx.

Shown by Mr. Wyatt Wingrave. The sections were stained by the Ehrlich triple Biondi process, a method which had the great advantage of differentiating the three most prominent histological elements, viz. the small-cell tissue, the epithelial cells, and the sclerotic bands. Neither in this nor in other instances had he been able to demonstrate a specific bacillus.

Apart from the question of the bacillus, he considered that histological differences between tubercle and lupus were to be explained by the respective rates of inflammatory changes.

Microscopic Sections of Papilloma of the Larynx.

Shown by Mr. Wyatt Wingrave. From a case of Dr. Dundas Grant's. It was of the simple stratified squamous variety.

Microscopic Sections of Rhino-scleroma.

Shown by Mr. Wyatt Wingrave. From a case of Dr. Dundas Grant's.

Specimen of Pachydermia Laryngis.

Shown by Mr. Lake. The larynx shown was removed from a patient æt. 34, who had been hoarse, or, as the patient had described it, "had had a man's voice since the age of four years." His family history was good. He had suffered with phthisis for one year, but his larynx showed no traces of this.

In reply to Dr. Grant, Mr. LAKE said the hoarseness antedated the phthisis by about thirty years.

TUBERCULAR LARYNX FROM A CHILD AGED 6 YEARS.

Shown by Mr. LAKE. This was shown on account of the comparative rarity of this disease in childhood. When first seen the child had laryngeal stenosis due to subglottic swelling; later destructive ulceration set in, and he died nine weeks later.

REPORT ON A SPECIMEN OF MEMBRANE (EPIGLOTTIS) FROM A CASE OF MEMBRANOUS LARYNGITIS SHOWN AT THE LAST MEETING (NOVEMBER) BY MR. LAKE.

Three organisms were shown to be present in the cultivations, viz.:

(1) *Staphylococcus pyogenes albus.*

(2) A small diplococcus (morphologically identical with the gonococcus, but staining by Gram's method).

(3) A small-celled torula.

WALTER D. SEVERN.

RECURRENT NASAL TUMOUR FROM FEMALE AGED 23.

Shown by Mr. LAKE.

EMPYEMA OF ANTRUM CURED BY REPEATED IRRIGATIONS BY MEANS OF LICHTWITZ'S TROCAR AND CANNULA.

Shown by Dr. DUNDAS GRANT. Mrs. M— was seen on July 21st, 1898. There was dulness on transillumination, and a free exit of fœtid pus following the use of Lichtwitz's trocar and cannula.

For nine years the patient had been subject to "colds in the head," chiefly affecting the right nostril, but the history of a fœtid discharge only dates about four weeks before her application for relief. Possibly the chronic recurring discharges were due to attacks of suppurative inflammation in the right frontal sinus from which the antrum was secondarily "charged." Transillumination of the right frontal sinus shows less translucency than that on the left side. The signs of antral empyema, which were typical, entirely disappeared after eleven irrigations with Lichtwitz's instrument. The teeth were sound, and

hence the intra-nasal treatment was adopted in place of any of the buccal methods.

Chronic Empyema of the Antrum cured by Intra-nasal Treatment (Anterior Turbinectomy—Krause's Trocar).

Shown by Dr. Dundas Grant. M. A. L—, æt. 31, schoolmaster, seen April 22nd, 1898, complaining of offensive purulent nasal discharge which had lasted continuously for six months. Antral empyema was diagnosed by means of Lichtwitz's trocar and cannula. Three carious teeth were removed, and the discharge did not return for two days. Temporary relief followed irrigation by the latter instrument. Alveolar puncture and irrigation were then instituted, and the latter carried out till June 18th, at the first with temporary success, but with pain in the process and no actual cessation of discharge. The alveolar puncture was allowed to close.

Anterior turbinectomy was then performed, and under cocaine Krause's trocar and cannula introduced; through the latter the antrum was washed out and then insufflated with iodoform and finally iodol. Twenty-eight irrigations through the alveolus had been unsuccessful, but after twelve through the intra-nasal cannula the discharge and smell had entirely ceased.

The patient is now quite free from any symptoms of his antral disease, there is no pus on irrigation, and the dulness on transillumination has diminished.

Dr. Herbert Tilley thought that the great disadvantage of this treatment was that in the majority of cases the irrigation had to be done by the surgeon rather than by the patient himself—a matter of very considerable importance. The alveolar method, which was without this disadvantage, made it most suitable for the general run of cases as the first line of treatment; for once the patient had been provided with a suitable plug and had been shown how to use the syringe, he could carry on the treatment for himself.

In reply to Dr. Spicer, Dr. Tilley said that he did not for a moment wish to underrate the value of the more radical operations in protracted cases, and cases where it was probable antral polypi were keeping up the discharge. He had himself found them invaluable. His contention was, that in ordinary cases associated with carious teeth the treatment should commence by removal of the latter and insertion of a plug, removable for constant irrigation; that the lotion should be constantly changed, and not until these methods were found to fail should more radical operations be performed,—one great

disadvantage of which was that patients could not carry out the treatment themselves. He was surprised that Dr. Spicer had met with so few cases cured by the alveolar method.

Dr. PEGLER thought the operation of anterior turbinectomy, as performed by Dr. Grant in this case, would become a more general accessory procedure in the treatment of antral disease where a Krause opening was to be made. He had noticed that the inferior turbinal tended to become chronically inflamed and swollen in the presence of much purulent discharge, and in its turn aggravated matters by hindering drainage and keeping up sepsis, besides rendering the Krause's opening more difficult of access. Subsequent treatment by irrigation with a catheter through this opening was also much facilitated by an anterior turbinectomy.

In reply to Dr. Tilley, Dr. PEGLER said he could show cases in which the habitual passage of a vulcanite catheter through the Krause opening, during home treatment by the patient, had been carried out, after a little practice, without any great difficulty.

Dr. SCANES SPICER felt it his duty to join issue with Dr. Tilley on two points. Firstly, as to the assumed difficulty of patients washing out the antrum per nares through the operative artificial ostium maxillare. With a proper bent tube, and one or two demonstrations, the patient found no difficulty in doing this within a few days of the operation. He had recently sent a case out of hospital fourteen days after radical operation, and as she was going to Bristol for a month he asked her to present herself at Dr. Watson Williams' clinic, and the speaker believed that that gentleman would say there was not the slightest difficulty. In fact, since he had adopted entire nasal irrigation after operation, he had found that patients had far less difficulty and discomfort than with the tooth-socket tube irrigation. Secondly, he protested against the routine use of tooth-socket tubes and a plate for "two months" in well-proved cases of *chronic* empyema. This doctrine was retrograde, and directly in opposition to all recent English, Continental, and American advances, and should be discountenanced by a society of specialists. Cases of cure of *chronic* empyema by tooth-socket tubes were most rare, while he had come across several cases of supposed "cures" who had gone on wearing their tubes for ten, fifteen and more years, and were still doing so, and using irrigations one, two, or three times a day for the suppuration and smell. It therefore appeared to him better to adopt at once a radical method which was safe, rapid, and practically certain, instead of wasting time and money on a method which almost never succeeded.

Dr. STCLAIR THOMSON suggested that in the matter under discussion the feelings of the patient might be slightly considered, and that in his experience when the facts of the case were put before a patient, the larger majority preferred to have the alveolar opening only whenever there was a suitable empty tooth-socket on the same side. A long history of suppuration does not necessarily mean an intractable case, for in his case, referred to by Dr. Scanes Spicer, the patient had had symptoms for seven years and the empyema had been definitely diagnosed two years before operation was decided upon.

Dr. WATSON WILLIAMS had had a case under his care which

showed the ease with which a patient could syringe out her own antrum.

Dr. GRANT, in reply, quite agreed that the convenience of the alveolar operation was such that it could never be altogether done away with. At the same time he had seen cases in which it had done no good, and improvement only began when the alveolar opening began to close and other methods of treatment were initiated. On principle he contended that an opening between the mouth and nose was bad physiologically, and still worse bacteriologically. He had therefore tried what could be done by intra-nasal treatment. He showed an instrument for enlarging the opening made with Krause's trocar, and cited a case in which such an opening had persisted. Anterior turbinectomy had at the same time been performed, and the patient could pass a Eustachian catheter into the opening.

X-RAY PHOTOGRAPH OF FOREIGN BODY (SILVER TUBE) IN THE ANTRUM OF HIGHMORE.

Shown by Mr. CHEATLE. The patient was wearing a tube through the canine fossa for chronic antral suppuration; the top broke off, and the patient continued to wear it. One morning on waking it had disappeared. In order to see if it was inside the antrum, Mr. Low took the photograph, which clearly showed it lying across the cavity.

Dr. DUNDAS GRANT had in one case of opening the antrum through the canine fossa found a vulcanite tube which had broken off from its plate. This had been adopted after the alveolar operation, and was supposed by the patient to have dropped out.

Dr. WATSON WILLIAMS cited a case where a peg similarly got lost in the antrum, but passed out into the nose through the ostium maxillare without operative interference.

Dr. WILLIAM HILL recorded another case where the loss of a tube in the antrum was fortunate for the patient, as it necessitated opening the front wall of the sinus, which was found to be diseased, and a radical cure was made of the case.

SPREADING ULCER OF THE NOSE.

Shown by Mr. WYATT WINGRAVE. Charles T—, æt. 50, labourer, seen on Nov. 14th, 1898, complaining of pain over nose and stinking discharge of six weeks' duration. On examination, nostrils were full of fœtid crusts, which on removal showed perforation of vomerine region of nasal septum with granulation tissue in all directions.

He gave a history of syphilitic sore thirty years ago, with falling of

hair, but no other signs. Married twenty years; wife had two miscarriages, at the second and fourth pregnancies. He had usually enjoyed good health. Two months later a red patch appeared on the outside of each ala at junction of bone and cartilage; this rapidly broke down and the ulceration spread to cheeks and upper lip, the tip of nose remaining free. He suffered considerable pain, and the discharge was profuse and fœtid. He was treated with pot. iodide and bromide, also inunctions of mercury, with negative results.

Cultivations were taken, but no special micro-organism was found, and injections of mallein and tuberculin gave no response. He has not lost flesh to any very great extent. The temperature has sometimes been as high as 103°, but for last six weeks has kept about normal. At the present moment the disease is not spreading as fast as it was, and the pain is but slight. He continues to take biniodide of mercury, which he has been under for the last three months. The ulceration is now much more superficial than it was, and shows a tendency to heal.

He thought that the case possessed interest from its resemblance to one which was presented to the Society by Dr. McBride in 1896, and seen by Sir Felix Semon and Dr. Milligan, who were all in doubt as to its nature.

The cases were alike in their resistance to mercury and iodides, their negative evidence of glanders, and their clinical history. He thought at first that it might be an unusually rapid case of lupus, since the history of syphilis was decidedly equivocal, and scrapings afforded no evidence of tubercle bacilli.

Mr. Spencer considered the case one of malignant ulceration, including under that term rodent ulcer. He would employ thorough erasion and the cautery, and later on cover healthy granulations with epidermal grafts.

Dr. Logan Turner said that he had had the opportunity of constantly observing Dr. McBride's case of destruction of the nose and face, which had been referred to by Mr. Wingrave. The microscope, bacteriological investigation, and specific treatment had failed to establish any diagnosis. In spite of operative interference the ulceration had extended and death followed. Post-mortem examination revealed nothing of a definite nature. It differed from Mr. Wingrave's case in the deeper and more complete destruction both of the soft parts and of the bones. In his (Dr. Turner's) opinion the patient now shown presented rather the appearance of a case of lupus.

Mr. Bowlby suggested that it might well be a form of rodent

ulcer, in which case the term epithelioma should not be applied, as they were not identical diseases.

In reply, Mr. WYATT WINGRAVE said that the fragments examined afforded no evidence of epithelioma or tubercle, and that no surgical treatment had been attempted. There was no response to the active mercurial treatment, which was thorough.

CASE OF SYRINGOMYELIA, WITH PARALYSIS OF THE RIGHT SIDE OF THE PALATE AND PHARYNX, AND OF THE RIGHT VOCAL CORD.

Shown by Dr. HERBERT TILLEY. The exhibitor expressed his great indebtedness to Dr. Risien Russell for the help he had given him in the examination of the patient's nervous system.

[Dr. Russell, at the invitation of the President, described the chief nervous symptoms of the case.]

C. S—, æt. 15 years, applied to the Golden Square Hospital, complaining of "hoarseness and inability to use her hands properly."

Patient's mother had "chorea" when seventeen years of age, and her mother's grandfather was the subject of fits, and died in an asylum. She was born at full term; labour difficult, and instrumental delivery with injury to the head resulted. Has always enjoyed fairly good health, but has always been subject to eczema of hands since quite young. Menses not established. Weakness of hands noticed first about two years ago, when she found she was unable to open her hands properly. Hoarseness seems to have existed before the latter trouble was noticed.

About two months ago she received a large burn on the hypothenar eminence of left hand, and knew nothing of it till the blister accidentally broke. She experienced no pain as the result of the burn.

Present state (*November* 28th, 1898).—Patient is a pale, well-nourished girl, with noisy breathing and a hoarse voice. Nystagmical jerks of both eyes are observed on lateral and upward movements; they are more marked when the eyes are directed to the right than when turned to the left, and the movements of the globus being lateral, with a certain degree of rotation added.

There is complete paralysis of the right half of the palate, pharynx, and right vocal cord, as opposed to a normal movement of the same on the left side.

All the neck muscles act well, and show no evidence of atrophy. The scapular and shoulder muscles, also those of upper arm, are intact, and all movements of the shoulder-joint and elbow are well executed. There is moderate wasting of the extensors and flexors of the forearms, with weakness of extension and flexion at the wrist—the defect being more marked in the extensors.

The fingers of both hands are in the "main en griffe" position, and there is marked atrophy of the small muscles of the hands on both sides, but more advanced in those of the left. The wasting of the thenar eminence and first interosseal space is more pronounced than elsewhere. The hand grasps are very feeble; separation and adduction of fingers feeble; inability to extend the second and third phalanges. Adduction of thumb possible, but feeble on both sides. Opposing power of thumb almost *nil*.

All muscles of forearm respond to faradism, but need a stronger current to evoke contraction than do those of the upper arm. No response of palmar muscles to faradism; dorsal interossei respond slightly. On right side, in addition to the response from the dorsal interossei there is very slight contraction of the palmar muscles. Markedly diminished reaction to galvanism is noted in the small muscles of the hands; no response in the palmar muscles (with the strength of current available, viz. one producing powerful response from normal muscles), including those of the thenar eminence on both sides. Dorsal interossei respond K.C.C. > A.C.C.

The trunk and back muscles are practically normal, but there is a pronounced lateral curvature of the spinal column, involving the whole of the thoracic vertebræ, and with its convexity to the right.

The lower extremities, both in nutrition and function, are normal.

Tactile sensibility is everywhere preserved, but there is blunting of painful impressions on both superior extremities; the analgesia, however, is not pronounced. There is complete loss of appreciation of thermal impressions all over both superior extremities, and there also appears to be a similar defect on the back of neck and trunk.

Thermal impressions seem to be normally perceived on the face, but there appears to be some slight defect on the neck and trunk down to the third rib on right side, and again from costal margin to about the level of the umbilicus; on the left side the defect appears to be more definite, and extends all the way down the neck and trunk to about the level of Poupart's ligament.

Knee-jerks are exaggerated, but no ankle-clonus can now be elicited as was possible a week ago.

Recent trophic disturbances are seen, and scars, the result of similar past affections in connection with skin of fingers; also some sores about the elbows, looking as if they were abrasion. Sphincters, thoracic and abdominal organs, present no clinical evidences of disease.

The PRESIDENT thought the case very interesting, as hitherto he had been unable to find any records of syringomyelia associated with laryngeal paralysis.

Mr. SPENCER pointed out that the nuclei in the lower third of the bulb giving rise to pharyngeal and laryngeal fibres were in this case affected, whilst the fibres arising from the upper part of the spinal cord, going to the sternomastoid and trapezius, were untouched. Doubtless in other cases both groups were affected. But the possibility of one group being alone attacked confirmed the view of a distinct origin.

HYPEROSTOSIS OF MAXILLARY AND OTHER BONES CAUSING NASAL STENOSIS.

Shown by Mr. BOWLBY. E. P—, æt. 43. She has noticed difficulty in nasal breathing and pain about eighteen months. She has been deaf to some extent for nineteen years, but has not got worse lately. Now complains chiefly of the frontal pain and difficulty of nasal respiration.

Present condition.—There is exophthalmos, especially on the left side. The left temporal fossa is occupied by a bony growth which is continuous with an enlargement of the left malar and superior maxillary bones. The left supra-orbital ridge is thickened. Both maxillary bones show overgrowth of their nasal processes, but the nasal bones themselves are not enlarged. There is a bony growth in the floor of each nostril, covered by smooth mucous membrane, and as large as a large almond. The turbinate bones also appear enlarged; the palate bones and the alveolar processes of the maxillæ are normal; the lower jaw is normal. Pulse 130. No tremors; occasional palpitations. Thyroid apparently normal. No definite evidence of syphilis, but has "had bad health" since marriage, has lost five out of six children, and had an "eruption on the face."

Mr. SPENCER asked Mr. Bowlby if he would try treatment by

thyroid extract on purely experimental grounds; it might do some good, and probably no harm.

A Case of Paresis of Left Side of Larynx.

Shown by Dr. Willcocks. J. T—, male, æt. 37, came under observation about the middle of November. The alteration in his voice began last April, accompanied by dyspnœa and noisy inspiration. For the last six weeks the voice has been worse. Patient had a penile sore followed by a rash about six years ago, and has also been a good deal exposed to vicissitudes of weather in his occupation.

The view of the interior of the larynx is much obscured by the epiglottis, which is very pendulous and almost immobile. The left arytænoid is much restricted in its movements on phonation, while the right side moves freely. There is no definite evidence of intra-thoracic pressure, such as aneurysm of the aorta, and there is no local evidence of disease in the larynx itself. The questions raised as to the nature of the condition were whether the partial paralysis on the left side was due to pressure on the left recurrent within the thorax (of which there is at present no definite evidence), or whether the restricted movement of the left arytænoid depended on some local mischief, such as adhesion, anchylosis, &c.

The Vice-President remarked on the difficulty that such cases as these presented as to whether the immobility was due to mechanical fixation or paralysis.

Dr. Lack had examined the case very carefully, and considered the appearances were those of recurrent paralysis and not of mechanical fixation.

Varix or Nævus of the Posterior Faucial Pillar.

Mr. Ernest Waggett showed a young man who had for a few weeks complained of pain and difficulty in swallowing.

A knot of dilated veins were to be seen under the mucous membrane of the left posterior faucial pillar, connected above with a small nævoid patch occupying the surface of the upper part of the corresponding tonsil. Attention had recently been drawn to the throat by frequent examination for throat lesions, necessitated on account of the occurrence of a suspicious sore on the penis. The symptoms

complained of dated from the occasion on which the patient for the first time became acquainted with the abnormality described, and his nervous demeanour warranted the symptoms being regarded as constituting a mere mental obsession. Presumably the abnormality was of congenital origin, or at all events one of very long standing, and, until recently, not noticed. No surgical procedure seemed called for.

Mr. WAGGETT, in answer to the Chairman, said that he was unaware that any lesion could be described as "a typical varix of the posterior pillar." He had shown the case as an unusual curiosity, and considered the condition to be very unimportant intrinsically, and one merely forming the basis of a pharyngeal obsession in a nervous patient.

A CASE OF FUNCTIONAL HOARSENESS IN A WOMAN AGED 37.

Shown by Dr. HECTOR MACKENZIE. The patient had been under observation for over six months. About the end of May she was sent up from the country to Brompton Hospital, supposed to be suffering from pulmonary and laryngeal tuberculosis. She had then been hoarse or aphonic for some months. She said her throat was painful, and that she had difficulty in swallowing. The history was strongly suggestive of tubercle. In June, 1897, she was said to have brought up a large quantity of blood. Her father died of phthisis when she was seven years old, and her mother died of asthma and lung disease. One was quite prepared, therefore, to find both pulmonary and laryngeal disease. On examining the larynx, however, one noticed the extreme tolerance the patient showed to examination, so that there was not the slightest difficulty in at once getting a thorough and complete view. This contrasted strongly with the great irritability usually exhibited in tuberculous cases. The movements of the larynx were irregular, and on attempted phonation the cords did not come together, while the ventricular bands tended to overlap them. In adduction the left arytænoid persistently occupied a position slightly posterior to the right. The mucous membrane was lax, but there was no sign of swelling or ulceration, and the cords were of a normal colour. No abnormal signs were found on examination of the chest.

From the appearances the conclusion was arrived at that the

laryngeal condition was functional. The faradic current was applied to the hands, with the result that the voice became at once quite normal. The voice remained normal for some weeks. The patient was greatly relieved in her mind by the restoration of the voice, and improved considerably in general health, putting on nine pounds in weight in six weeks. There has been a tendency for the hoarseness and aphonia to recur, but the voice has always been easily restored to a normal condition by the application of the battery. Unfortunately the patient lives at a considerable distance from London, so that treatment has been carried out at some disadvantage.

Dr. StClair Thomson was of opinion that the laryngitis was entirely functional. If the patient was put through certain vocal exercises with the laryngeal mirror in position, it was seen that the vocal cords were perfectly healthy and mobile, and that the ventricular bands were much hypertrophied. The patient, in fact, had developed what the Germans call "taschenbandsprache," and he thought that with suitable exercises she might be induced to desist from speaking with her ventricular bands, and return to the natural use of her vocal cords.

Dr. Grant suggested that she should constantly practise inspiratory phonation, which he had found useful in a similar case.

Papilloma of Tonsil.

Shown by Mr. de Santi. The patient, a girl æt. 19, suffered occasionally from enlarged tonsils. No other trouble. When examined a papillomatous growth was discovered on left tonsil. The tonsil and growth were removed together.

Malignant Disease of Nose in an Old Man.

Dr. Bond showed a case on whom radical operation on the nose and two operations for removal of glands had been performed, the patient having twice previously been shown to the Society and reports made on microscopic sections of tissues removed.

In May, 1898, the nose was clear of disease, but there was a large mass of glands in left side of neck the size of a hen's egg. This was cut down upon and removed with all adherent structures, viz. much of the sternomastoid fasciæ, the internal jugular vein, and the spinal

accessory nerve. The patient is now apparently free from malignant disease and in good health.

The case is of interest since—1st, the left side of palate and left cord have become paretic; 2nd, the remnant of left sternomastoid and trapezius have wasted; 3rd, the general condition of the patient is good, after suffering from undoubted malignant disease for some six years.

In reply to the Vice-President, Dr. BOND thought that the paralysis of the cord might be explained by the fact that the vagus was considerably pulled about during the operation, and of course it was possible that pressure was being exercised upon it by a deeper set of glands.

RECURRENT PAPILLOMA OF LARYNX IN GIRL OF 18.

Shown by Dr. BOND. This patient came to Golden Square about eight years ago with papilloma of larynx, which she seems to have had all her life. When first seen, in 1892, she had not, and was said never to have had, any voice. She was thought to be dumb, was said to have no laugh, and had considerable dyspnœa. Both cords were covered with papillomatous growth on the upper surfaces and edges, and there was a considerable amount below cords in front. The growths have been cleared away every few months during the last eight years. The patient has now a fair voice and the cords are almost clear, though it is some four months since the last operation. The case is of interest owing (1) to the great length of time during which the growths have persisted; (2) to the fact that the growths are recurring with less and less vigour as the patient gets older; (3) the fact that a child of ten could be thought to be dumb owing to the presence of these growths seems a novelty in laryngology.

In reply to a question by the Vice-President as to whether Dr. Bond had used any local applications, the latter said that perchloride of iron grs. vij ad ℥j had been used.

Dr. GRANT suggested the use of a 5 per cent. solution of salicylic acid and absolute alcohol.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ANNUAL GENERAL MEETING, *January 6th*, 1899.

HENRY T. BUTLIN, Esq., F.R.C.S., President, in the Chair.

HERBERT TILLEY, M D., } Secretaries.
WILLIAM HILL, M D., }

Present—45 members and 3 visitors.

The minutes of the Sixth Annual Meeting were read and confirmed.

Mr. Wyatt Wingrave and Mr. Milsom Rees were appointed Scrutineers of the ballot for the election of Officers and Council for the ensuing year; they reported the result of the ballot as follows:

President.—F. de Havilland Hall, M D.
Vice-Presidents.—A. Bronner, M.D.; W. H. Stewart, F.R.C.S.Ed.
Treasurer.—Clifford Beale, M.D.
Librarian.—J. Dundas Grant, M.D.
Secretaries.—William Hill, M.D.; Lambert Lack, M.D.
Council.—Edward Law, M.D.; Walter Spencer, M.S.; F. W. Milligan, M.D.; A. Bowlby, F.R.C.S.; Herbert Tilley, F.R.C.S.

The following Report of Council was then read and adopted:

The Council are pleased to report the continued prosperity of the Society, as evinced by the increase in the number of its members and the enthusiasm thrown into the work of the ordinary meetings.

Thirteen gentlemen have been elected ordinary members during the past year, which including the nine honorary members brings the total membership of the Society to 135.

The meetings of the Society have been well attended, the average of thirty-five attendances for the ordinary meetings during the past year being the highest hitherto recorded.

A special meeting of the Society was held July 13th, 1898, to discuss—1. Whether it was desirable to limit the membership of the Society. It was decided to add the words "and as proficient in laryngology" to the present declaration on the nomination paper, and also that the name of each candidate for election should be brought before the Council before being submitted to the ordinary meeting for election.

2. Whether, in deference to the opinions expressed by certain provincial members, it was desirable to alter the day of the ordinary meetings. A letter was sent to each member of the Society asking his opinion in the matter, and in accordance with the wishes expressed by the majority of those who replied, it was decided to hold the ordinary meetings on the first Friday of the month in place of the second Wednesday as heretofore.

Bye-laws were passed giving effect to these alterations in the Rules, subject to confirmation at the next Annual Meeting (January 6th, 1899).

During the past year two gentlemen have resigned their connection with the Society, and we have to regret the loss through death of Mr. John Fallows, L.R.C.S.Ed., who perished in the wreck of the Mohegan.

The Society especially deplores the early death of Professor A. A. Kanthack, lately of Cambridge University. Professor Kanthack was one of our original members, and made many valuable contributions to our Proceedings. Before he determined to devote himself to pathology he turned his attention to laryngology, and, while in Berlin, studied with success some interesting points in the anatomy and pathology of the larynx. The results of his researches were published in 'Virchow's Archiv.' After he had given up clinical medicine and surgery he still continued his interest in matters connected with laryngology, to the good fortune of our Society, which loses in him one of its most active and able members.

The Treasurer's Annual Statement was then presented as follows:

The actual receipts for the year are £152 5*s*. This amount includes six subscriptions for 1899 and one for 1900.

There are still fifteen subscriptions (£18 18*s*.) outstanding for 1898, the majority of which are good.

The seven outstanding subscriptions for 1897 (£7 7*s*.) mentioned in last year's report have been paid during the current year.

The actual expenditure is £111 10*s*. 6*d*., which leaves a balance for the year of £40 14*s*. 6*d*. This, added to the balance from 1897 (£170 0*s*. 5*d*.), leaves in the Treasurer's hands a total balance of £210 14*s*. 11*d*.

BALANCE-SHEET, 1898.

Income.	£	s.	d.
Balance from 1897	170	0	5
111 Subscriptions at £1 1s. .	116	11	0
12 „ at £2 2s. .	25	4	0
1 Compounding Fee at £10 10s.	10	10	0
Total . .	£322	5	5
The income for the year is . . .	£152	5	0

Expenditure.	£	s.	d.
Rent and Electric Light (20, Hanover Square)	31	10	0
Adlard for Printing and Postage, May, 1897, to August, 1898	71	18	3
Strangeways (Photo-engravings)	1	0	0
Professor Kanthack (refunded for hire of microscopes)	1	10	0
Indexing volume, 1898 (Clarke)	1	1	0
Mathew (porter), 3 meetings (1897), 8 meetings (1898) .	1	18	6
Petty Cash—			
Rogers (Carbolic Acid and Spirit) . . £0 10 6			
Receipt books (Creswick) 0 6 6			
Bank Charges . . 0 0 6			
Baker (hire of microscopes) 0 12 0			
Dr. Tilley (secretarial expenses) . 0 11 3			
Hon. Treasurer's expenses (postage, &c.) 0 12 0			
	2	12	9
Balance in Treasurer's hands	210	14	11
Total . .	£322	5	5
The expenditure for the year is . .	£111	10	6

Audited and found correct, *January* 6, 1899. { PHILIP R. W. DE SANTI. L. HEMINGTON PEGLER.

The following embodies the Librarian's Report, which was then read:

I beg to report that since the last Annual Meeting I have received the following periodicals, and shall endeavour to have them bound in time for the next meeting:

Revue Internationale de Rhinologie, Laryngologie, et Otologie (Natier).
Revue hebdomadaire de Laryngologie, d'Otologie, et de Rhinologie (Moure).
Archivi Italiani di Laringologia (Massei).
Belletino delle Malattie, &c. (Grazzi).
Archiv für Laryngologie (Frankel).
Journal of Laryngology (D. Grant).
Laryngoscope (StClair Thomson).
Annales des Maladies de l'Oreille, du Larynx, du Nez, et du Pharynx (Gouguenheim).
Monatsschrift für Ohrenheilkunde (Gruber).
The Brooklyn Medical Journal (Vol. XII. from June).

Moure, Dr. E. J. De la Tracheo-thyrotomie dans le Cancer du Larynx (Travail de la Clinique de Moure).
Moure, Dr. E. J. Sur les Traitement des Sinusites (Travail de la Clinique de Moure).
Moure, Dr. E. J. Traitement de l'Ozène (1897).
Catalogus van de Boekerij der Nederlandsche Keel-, Neuw-, en Oorheelkundige Vereenigung, 1897 and 1898.
Brighton and Sussex Medico-Chirurgical Society Proceedings and Annual Report, 1897–8.
Gesellschaft der Ungarischen Ohren- und Kehlkopfärzte Jahrbücher, Band III.
Niederlandische Gesellschaft für Huls, &c., 1897–8.
Laryngologische Gesellschaft zu Berlin Verhandlungen, Band VIII.
American Laryn. Assoc. Transactions of the 19th Annual Meeting.
Eighteen Monographs in reprint from Professor Gradenigo.
Five Monographs in reprint from Professor Grazzi.
Several microscopical specimens have been added to the Society's collection, including Lupus of the Larynx (Professor Massei).
Volumes bound as completed.

The following bye-laws (*vide* Council Report) and suggestions from the Council were then discussed, and it was agreed that they should henceforth be regarded as rules of the Society :

(*a*) That the words "and as proficient in laryngology" be added to the nomination papers for future candidates. (Special meeting, July 13th, and Council meeting, October 7th.)

(*b*) That the names of candidates for the membership of the Society shall be submitted to the Council before being placed before the ordinary meeting for ballot. (Council meeting, October 7th.)

(*c*) That the ordinary meetings of the Society be held on the first Friday (instead of the second Wednesday as heretofore) in each month, from November to June inclusive (see Rule 19). (Council meeting, October 7th.)

(*d*) That in Rule 3 the reference to provincial members be expunged. (Council meeting, December 2nd.)

The Forty-sixth Ordinary Meeting of the Society was subsequently held, the President being in the Chair.

Chronic Nodular Laryngitis in a Boy aged Fifteen.

Shown by Dr. StClair Thomson. This case was shown as illustrative of the nodular laryngitis of children described by Moure of Bordeaux. This latter observer, however, had attributed the condition to the straining of the voice, especially in children with treble voices who were compelled to sing seconds. In the present case there was no such history of voice abuse. He was brought with a history of a few months' hoarseness, but

on further inquiry it appeared that he had been more or less hoarse since an attack of croup at the age of three or four. On examination it would be seen that there was a rounded thickening at the junction of the middle and anterior thirds of both vocal cords—the usual site of singers' nodules,—but in the present instance, instead of being situated on the free margin, the nodules were on the upper surfaces.

The cords were generally injected. Some adenoids had been removed in October last without relief, and since then he had been treated with insufflations of alum, sprays of iron, lactic acid, &c., without relief. Rest to the voice has been prescribed.

Dr. DE HAVILLAND HALL thought that at the present time Dr. StClair Thomson would probably feel inclined to alter the nomenclature of the case, as the appearances were those of a chronic laryngitis, the nodules not being distinct. The case, in Dr. Hall's opinion, resembled a chronic laryngitis due to nasal obstruction.

TWO CASES OF CHRONIC LARYNGITIS, ENTIRELY LIMITED TO THE RIGHT VOCAL CORD, AND PROBABLY TUBERCULAR IN CHARACTER.

Shown by Dr. STCLAIR THOMSON. One case was that of a young woman who had been hoarse for more than a year; the other was that of a man who had been hoarse for the last nine months. He had at one time lost flesh, but had latterly put on weight. In neither case were there any definite physical signs in the lungs, and there was no expectoration to examine. The temperature was not raised. In each case there was a red fleshy condition of the right vocal cord, and it was interesting to note, as confirmatory of Dr. Jobson Horne's pathological researches on this subject, that the free edge of the cord was but slightly affected, while the granulations on the cord appear to originate from the mouth of the ventricle of Morgagni. The diagnosis was arrived at by a process of exclusion. Both cases were decidedly improving under general treatment, although they lived in London.

Dr. HALL thought that the evidence in favour of a tuberculous laryngitis was not decisive in Dr. StClair Thomson's second case.

Dr. CLIFFORD BEALE observed that the limitation of the affection to one or the other side of the larynx must always be a strong point in diagnosis in cases of doubtful tubercular infiltration where evidence of other specific diseases was wanting.

Dr. Herbert Tilley agreed with Dr. Thomson in looking upon these cases as tubercular. The speaker had shown at a former meeting a man who had tubercular ulceration of the tip of the epiglottis which had been almost completely cured by lactic acid applications and curetting. He had had him under observation nearly twelve months, and when he saw him two days ago he noted a marked granular congestion of the left vocal cord and vocal process, the rest of the larynx being normal. There was well-marked tubercular mischief in both pulmonary apices.

Dr. StClair Thomson in reply said he had been led to the diagnosis of tuberculosis in these cases by the one-sidedness of the affection, the absence of symptoms of new growth or syphilis, the chronic nature of the complaint, and the situation and appearance of the fleshy granulations. It was hardly likely that a simple chronic catarrh would remain limited to one vocal cord for a whole year, and that it would not disappear completely under vocal rest, such as these patients had tried. Recovery—and these two cases were improving—was not necessarily opposed to this view, for tuberculosis of the larynx, as of other parts, got well, and in some instances even without treatment.

Sir Felix Semon said that whilst fully recognising the diagnostic importance of isolated congestion of one vocal cord—a point, in fact, which he had always emphasised himself—he should not go so far as to make a definite diagnosis from this appearance alone. In his opinion the discovery of such an isolated congestion ought to draw the observer's attention to the possibilities of tuberculosis, malignant disease, and syphilis, and no doubt in the majority of cases one of these affections would be found later to develop in the congested part; on the other hand, however, he looked back personally upon a small but definite number in which such an isolated congestion was not followed by any further untoward developments. He should not, therefore, pin his faith upon the discovery of the appearance named alone, but simply look upon it as a valuable warning signal.

Case of Cure of Chronic Empyema of Maxillary Antrum by Radical Operation.

Dr. Scanes Spicer showed this patient, operated on by him six weeks ago.

A. B—, æt. 23, eight years ago had attacks of pain and recurrent abscesses for two years over region of left upper first molar. Six years ago this tooth was removed, and there has remained a fistulous track high up on anterior wall of gum, discharging fœtid pus on and off ever since. In October, 1898, increase of swelling, pain, and fœtor in left nostril. No loose bone could be detected with a probe. Patient, actively engaged

in business, pressed for an immediate cure. Exploration was advised under an anæsthetic, and permission obtained to remove any sequestrum, or to deal with the antrum as might be deemed necessary.

On November 29th this was done. A large gap was found in the anterior bony wall of superior maxilla of irregular shape, and in the membranous structure filling this gap were small, loose, thin, bare scales of bone. The probe and finger easily passed into the antral cavity, which was filled with thick inspissated pus, cheesy débris, also polypi and granulation tissue, with indescribable fœtor. The cavity was thoroughly cleaned out, and the naso-antral bony wall found to be similarly absorbed; the finger passed into the antrum with the slightest pressure met the finger passed into the corresponding nasal fossa, breaking through the membranous portion in the inferior meatus region. The opening was enlarged with finger and curette so as to admit a large drainage-tube, which was cut off near the nostril, and the tube secured by silk threads tied behind each ear. The muco-antral opening was sutured (apparently not sufficiently so, as this incision has not yet healed).

The patient's doctor carried out all subsequent irrigation and drainage by this nasal tube, and after its removal in five days through the naso-antral opening.

Patient reports there has been no pus or fœtor since the end of the third week.

The case is interesting for the following reasons:

(1) It exemplifies the polypoid proliferation and caseation of retained pus, so usually found in chronic antral empyema.

(2) There was a co-existence of a rarefying osteitis of superior maxilla with necrosis of small scales of bone, rendering use of trephines, gouges, or Krause's trocar unnecessary to open and drain the antrum.

(3) The cure of fœtor and suppuration of eight years' standing was rapid, and performed well within the time allowed the patient by his governing board.

Specimen of Dead Bone, Polypi, and Débris removed from a Case of Chronic Empyema of Antrum cured by Radical Operation in Eight Weeks.

Dr. Scanes Spicer showed this specimen. The patient from whom it came, E. P—, female, æt. 18, had complained of unilateral nasal stench and evacuation of foul crusts for nearly eighteen months. This stench was relieved by the evacuation of a crust, and then gradually increased for two or three days, until another crust was discharged. All teeth were present and apparently sound. Diagnosis confirmed by transillumination. Patient's parents had brought her from the north of England for cure, and were staying in London for that purpose. Radical operation as in last case was advised and performed. The patient returned after eight weeks with no fœtor or suppuration, and several reports up to Christmas, 1898, state there is no recurrence of fœtor or pus as before.

The presence of the sequestrum (suspended in the bottle by a silk thread), and the polypi, &c., which filled the bottle at time of operation, indicate the extreme improbability of cure being effected by tooth socket tube.

Dr. Scanes Spicer also showed the temperature chart of another patient on whom he had performed the radical operation in St. Mary's Hospital for cure of chronic empyema of antrum, to illustrate that the modern form of operation was by no means the severe and dangerous procedure which had been stated. On no day had the temperature subsequent to operation exceeded the normal by a degree. The patient will attend at a subsequent meeting.

Further Report of Case of Sarcoma of the Nose shown at November Meeting.

Dr. Barclay Baron (Bristol) reported that he had sent a piece of growth removed from his case of sarcoma of the nose shown at the November meeting to the Morbid Growths Committee. They reported it to be an alveolar sarcoma, and showed sections of it at the December meeting. The growth rapidly increased

both within the nose and externally, displacing the eye outwards. At Dr. Baron's request, Mr. Charters Symonds kindly undertook its removal, full view of the growth being obtained by enlarging the opening in the superior maxilla made by the disease. The dura mater was found to be exposed in one place, the bone covering it having been destroyed, and it would, therefore, have been a dangerous procedure to attempt to curette the interior of the nose without seeing what was being done.

The patient made a quick recovery, and there is very little disfigurement.

Mr. SYMONDS, in describing the operation, said that when he first saw the case in the wards at Guy's Hospital it seemed to him to presently clinically the ordinary appearance of a sarcoma of the nasal fossa. The elastic projection at the inner corner of the eye which had been noticed in November had projected and displaced the eye both upwards and outwards. In respect to the various opinions expressed as to the nature of this swelling, he carefully exposed it and found it to be composed chiefly of soft growth. It was limited by the stretched periosteum, and between the two was some thick nasal mucus, an arrangement which would account for the sense of fluctuation. The incision was carried down to the ala of the nose and another outwards below the orbit, then with a keyhole saw a part of the nasal process of the superior maxilla, and of the floor of the orbit and anterior wall of the maxilla, were removed. The aperture thus obtained, together with that made by the growth, which had destroyed the lachrymal bone and a part of the ethmoid, gave a large opening into the upper part of the nasal cavity. Through this the entire growth was removed. A sterilised pad was plugged into the posterior naris. On removing the growth the dura mater, as Dr. Baron had mentioned, was exposed; this was not due to the forcible removal of bone, for the growth itself lay in contact with this membrane. That it was dura mater was clear from its bluish-white colour and its density; thus it was obvious that a large part of the ethmoid had been destroyed, and that the starting-point of the new growth was somewhere in the mucous membrane covering this bone. The mucous membrane round the area was cut away with scissors, including the middle turbinal, and the edges of bone around the site were also removed by cutting forceps. The maxillary sinus, which had been slightly opened, was freely laid bare by removing the inner wall. The wound was sutured, and the patient went home in a week. The eye returned nearly to the normal position, and the movements were unaffected and there was no diplopia. The microscopic examination which was made by the surgical registrar at Guy's Hospital, Mr. Fagge, confirmed the report of the Morbid Growths Committee that it was alveolar sarcoma. The structure was identical in all parts of the tumour: it may be added that the growth extended from the nostril to the pharynx, but did not occupy the antrum.

In his report Mr. Fagge stated that the microscopic appearances were those not uncommon in neoplasms of the nasal fossæ.

Mr. Symonds added that he usually, in operations upon the upper jaw, preferred, instead of the set procedure usually recommended, to use a keyhole saw, and surround the growth, leaving any portion that appeared to be quite healthy, for in this way more or less of the palate in some cases might be preserved.

Specimen of Peg removed from Maxillary Antrum through Ostium Maxillare.

Shown by Dr. Watson Williams.

Lupus of Nose.

Shown by Mr. Wyatt Wingrave. Female æt. 30 complained of nasal obstruction with discharge of five years' duration. Four months ago the floors of both nasal fossæ were found occupied by granulations, which extended as high as the middle turbinals. Large quantities were removed by sinus forceps and curette, only to be followed by rapid recurrence. They are much less numerous now, but have involved the turbinals. The cartilaginous septum is perforated, and there is some evidence of old pathological changes in the soft palate. The larynx is normal.

Owing to the large amount of granulation tissue, the existence of severe pain, and evidence of caries on probing, syphilis was suspected, but no history could be obtained, and she did not respond to specific treatment. The tissue on examination gave no evidence of tubercle bacilli, but presented the usual features of lupus.

She has lost one brother and one sister from consumption, and suffers from lung trouble herself.

Mr. Cresswell Baber and Dr. Thomson thought the appearances and fœtor resembled syphilis.

Dr. Watson Williams suggested that in the discussion of such cases the terms lupus and tubercle should be used synonymously, as they were essentially identical diseases, and differing only in their chronicity and mode of growth.

Dr. de Havilland Hall upheld this restriction of nomenclature.

Tubercular Laryngitis in a Dwarf.

Shown by Dr. Herbert Tilley. Patient is a female æt. 45, height 3 feet 2 inches. In February, 1898, she had an attack of influenza and bronchitis, since when she has had a chronic cough and hoarseness.

The larynx is very small, the vocal cords being only about 15 mm. long; both of them were ulcerated, also the right vocal process.

Tubercle bacilli had been found in the expectoration.

Two Cases of Epithelioma and One of Sarcoma of the Larynx treated by Thyrotomy, and keeping well two and a half years, one and a half years, and six months respectively after operation.

Shown by Sir Felix Semon. Case I (already described by the patient himself, Mr. C. Fleming, L.R.C.P., &c., in the 'Lancet' of October 16th, 1897).—Medical man, æt. 47, noticed in June, 1895, slight huskiness, which steadily increased. In November a whitish, pointed, sessile thickening was seen in the middle of left vocal cord. The cord itself congested, its movements free. In May, 1896, voice much worse, no other symptoms. Posterior part of left vocal cord generally thickened, slightly œdematous, no distinct growth visible, movements of cord still free. Two months later conditions unchanged. Proposal of exploratory thyrotomy supported by Mr. Butlin. Operation on July 21st, 1896. Left vocal cord was found to be tumefied in its entire length, and was removed with an area of healthy tissue around it. Mr. Shattock pronounced the growth as a typical squamous-celled carcinoma in the early stage, with little horny transformation. Convalescence took place without any complications, and the patient resumed his practice within a month from the performance of the operation. Since then perfectly well. Voice very good. On laryngoscopic examination a marked cicatricial ridge is seen in the position of the former left vocal cord.

Case II.—Naval officer, æt. 57, sent by Dr. Clay of Plymouth on March 30th, 1897, on account of increasing hoarseness. Both

vocal cords very irregular, considerably thickened and congested, particularly in their anterior two thirds. Their movements free. Differential diagnosis between chronic laryngitis and malignant disease doubtful. The latter suspected on account of the unusual amount of thickening, and expectoration on one occasion of slightly blood-tinged sputum. Two months later hardly any change. Consultation with Mr. Butlin, who shared my suspicion of malignancy. Intra-laryngeal removal of some small projecting pieces of the general thickening for microscopic examination. Mr. Shattock's report on the largest of these ran as follows:—"I took the greatest pains to cut the section of the small flat piece of tissue at right angles to its slightly uneven and granulated surface. The result was wholly successful, and then I saw at once that the growth is a squamous-celled carcinoma. It is so marked that there can be no two opinions about it. The growth has a slight tendency to be horny, *i. e.* less malignant than other forms." Operation on May 31st, 1897. Thorough removal of both vocal cords, scraping of bases. Uninterrupted convalescence. Two months afterwards granulation tumour in anterior commissure, which was removed intra-laryngeally. Patient has enjoyed good health since operation, but the voice of course has been reduced to a whisper, as *both* vocal cords had to be removed, and as the cicatricial ridges which have been formed do not compensate for their loss.

Case III.—Private gentleman, æt. 69½, sent by Dr. Branfoot, of Brighton, on July 15th, 1897, on account of gradually increasing hoarseness, which had already lasted several months. A reddish, irregular, mammillated, broad-based growth occupied the greater part of the much congested right vocal cord, beneath which it seemed to pass into the subglottic cavity. Mobility of cord, if at all, certainly not much impaired. Differential diagnosis doubtful between fibroma and malignant new growth. Microscopic examination (Mr. Shattock) of intra-laryngeally removed fragment showed the tumour to be a sarcoma, nowhere undergoing fibrous transformation, but in part the seat of leucocytic infiltration, and altogether apparently of a highly malignant type. Thyrotomy on July 21st, 1898. The thyroid cartilage was completely ossified, and had to be divided by sawing. The larynx having been opened, it was seen that the growth was

partly pedunculated, but in part infiltrated the anterior part of the right vocal cord. The growth and the anterior half of the right vocal cord were removed and the basis scraped. The posterior part of the right vocal cord was stitched to the right ventricular band. The whole wound was immediately closed after operation, and only a small drainage-tube left in its lowest part. This, too, was removed on the second day after operation. The temperature rose in the evening of the first day to nearly 101°, and came only very gradually down until the normal was reached on the sixth day. In all other respects uninterrupted progress. The patient returned home a fortnight after operation, and ever since has been perfectly well. His voice has an almost normal character, and is still improving in strength.

Mr. Spencer asked for information on three points: (1) What antiseptics were used. (2) Whether the thyroid cartilage was always sutured. (3) Whether the muscles of the neck were sutured together before closing the skin wound.

Sir Felix Semon (in replying to Mr. Spencer) said that his methods of operation had been described in the 'Lancet' of 1894, and in the 'Archiv für Laryngologie' for 1897; that he always rubbed iodoform into all the tissues before closing the wound; that he sutured the thyroid cartilage by means of catgut or silver ligatures; that he now closed the wound in its entire length, withdrawing the sponge cannula immediately after the operation, and only left in its lowest part a drainage-tube; that he was not quite certain whether this modification represented a real improvement, as he thought he had observed that the temperature kept up longer than when the lower third of the wound, as previously, was left open for three or four days, and that he might possibly revert to the latter method. He had only once had to suture the *muscles*, and this was in a case of *tubercular* disease of the larynx, in which the wound had become infected. He added that the appearance of a tumour in the anterior commissure of the vocal cords was—to conclude from his own experiences—rather suggestive of the formation of a granuloma than of a recurrence of the malignant growth; and secondly, that a recent communication of Professor Chiari's in the 'Archiv für Laryngologie' had shown him that the idea of painting the laryngeal mucous membrane with a 20 per cent. cocaine solution to diminish bleeding and reflex irritation had not originated with him, as he had thought, but that he had been forestalled with regard to this by the late Professor Billroth.

Specimens.

Dr. Milligan showed the following specimens:

1. Lymphangioma of Vocal Cord.
2. Laryngeal Papilloma.
3. Naso-pharyngeal Fibro-sarcoma.
4. Large Exostosis removed from Maxillary Antrum.

Multiple and Diffuse Papillomata of the Larynx.

Dr. Jobson Horne showed a case of multiple papillomata occurring in the larynx of a woman æt. 22. Change of voice had been noticed by the patient's friends for upwards of eighteen months, gradual in onset,—at first only a roughness of voice, which had developed into complete hoarseness. Difficulty in respiration had been experienced after physical exertion, especially after going up and down stairs, and after prolonged talking. Latterly the patient has been distressed by nocturnal attacks of dyspnœa on first lying down, but had not been disturbed by them in the course of the night. It was on account of these attacks that the patient first sought advice.

Laryngoscopic examination showed a subcordal mass of papillomata attached in the neighbourhood of the anterior commissure, which when driven upwards during phonation occupied more than half the glottis. Diffuse papillomata also covered both cords.

The subcordal mass was removed, and the attacks of dyspnœa had ceased, and some improvement had taken place in the voice.

The growth under the microscope was found to be a simple papilloma.

Tubular Epithelioma of the Nose.

Dr. Bronner (Bradford) showed a microscopic specimen of a tubular epithelioma of the nose. The growth was of the size of a large pea, and had been removed from the nasal mucous membrane just above the anterior part of the lower turbinated bone of a man of forty-seven nearly ten years ago.

There was a history of slight nasal obstruction and frequent slight hæmorrhage from the nostril. The growth had been removed by scissors, and the base then thoroughly burnt with the galvano-cautery. There has been no recurrence. The report of the Clinical Research Association was :—"The growth is malignant, of an epithelial type; it may be classed with the tubular epithelioma. At the periphery beneath the mucous membrane tubules with a definite lumen can be seen.

Mr. BUTLIN thought it would be very difficult to decide whether it was an adenoma or carcinoma, and suggested that sections should be made by the Morbid Growths Committee.

CASE OF RIGHT RECURRENT PARALYSIS WITH PARESIS OF TRAPEZIUM, STERNO-MASTOID, AND PALATE, WITH SLIGHT PTOSIS AND FACIAL PARALYSIS, ALL ON THE SAME SIDE.

Shown by Mr. R. LAKE. This patient, an intelligent man æt. 36, was sent to me for an affection of the larynx. The following history was obtained. Eleven years ago he was stabbed over right eye, and had subsequently Jacksonian (?) epilepsy, the last attack twelve months ago. No history of syphilis. He has had a cough since August, 1898, and loss of voice for three weeks, dysphagia, and food going the wrong way for two months. His right shoulder is lower than the left; wasting and want of power are noticed in the trapezium and sterno-mastoid, some paresis of palate; reflex present on both sides, the same with pharynx. Left pupil large, and only reacts slightly to accommodation, but not to light. Slight right ptosis and loss of power in the right labial muscles. No Romberg's symptoms. The patient has been taking 90 grains of iodide of potash daily, and had mercurial inunctions every other day for the past six weeks. The dysphagia is getting worse; the voice is now, and has been for the last week, nearly normal.

GROWTH OF LEFT VOCAL CORD IN A MAN AGED THIRTY-TWO.

Shown by Mr. C. A. PARKER. *History.*—Voice began to be slightly husky about the middle of August last. The huskiness varied at first, but has been getting gradually worse during the

last eight weeks. The patient is a tea inspector, and he is constantly inhaling tea dust. There is no loss of flesh and no history of syphilis.

When first seen on October 14th there was a large growth of left vocal cord, especially affecting the anterior half of the cord, where there appeared to be a superficial slough. From its appearance it seemed to be a simple papilloma. The cord was then moving freely.

On October 28th the anterior portion of the growth was removed and examined microscopically by Dr. Hewlett, who reported it to be a papilloma. Since then the growth has recurred to a great extent, and now looks more an infiltration of the cord than a growth attached to the cord; meanwhile the movement of the cord has become impaired.

The case is before the Society for suggestions on the diagnosis and treatment. It seems at present to be something more than a simple papilloma, and in spite of his age (thirty-two years) one is inclined to think it may be a case of early malignant disease.

He has taken 10 grains of iodide of potassium three times a day for six weeks without the slightest improvement.

Sir FELIX SEMON thought it looked very like malignant disease, and advised thyrotomy.

Mr. DE SANTI expressed similar views.

AFTER HISTORY OF A CASE OF RECURRENT PARALYSIS OF VOCAL CORD.

Dr. WILLCOCKS, who showed the patient at the December meeting, reported that he had since had pneumonia, and died suddenly of intra-thoracic hæmorrhage, pointing with little doubt to aneurism which during life had presented no physical signs.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ORDINARY MEETING, *February 3rd*, 1899.

F. DE HAVILLAND HALL, M.D., President, in the Chair.

WILLIAM HILL, M.D., }
LAMBERT LACK, M.D., } Secretaries.

Present—31 members and 3 visitors.

The minutes of the previous meeting were read and confirmed.

The PRESIDENT briefly thanked the members of the Society for the honour they had conferred on him in electing him to preside at their meetings. He promised that he would spare neither time nor energy in furthering the interests of the Society, and in endeavouring to maintain the high standard of his distinguished predecessors in the chair.

The President announced that at the Council meeting just held it had been decided, owing to the large number of clinical cases shown, to increase the number of the electric lamps. To facilitate the reporting and enhance the value of the proceedings a shorthand writer would attend at the next meeting. It was decided further that one meeting, viz. May 5th, should be entirely devoted to a discussion on "Asthma and its relation to diseases of the upper air-passages."

The following gentlemen, their names having been previously submitted to the Council, were nominated for election at the next meeting:

H. Fitzgerald Powell, M.D.(St.And.), F.R.C.S.Edin. Practice, Laryngology and its branches.

Mark Purcell Mayo Collier, M.S., F.R.C.S. Practice, Laryngology and Surgery.

St. George Caulfield Reid, M.R.C.S. Practice, General and Special.

Dr. Lack was elected a member of the Morbid Growths Committee in place of the late Dr. Kanthack.

The following cases and specimens were shown.

Slight Defective Abduction of the Right Vocal Cord.

Shown by Mr. H. Betham Robinson. F. E—, æt. 37, came on December 22nd, complaining of increasing weakness of his voice in singing for some three months, with some pain on the right side of his neck. There was no sore throat and no cough, but occasionally he had night sweats.

His occupation is that of clerk, but he sings a good deal. No history of syphilis.

His father had disease of the knee-joint after an injury ten years before; for this it was excised and subsequently amputated, from which operation he succumbed.

On examination there was slight impaired abduction of the right cord with some injection of both cords; there was no other intra-laryngeal lesion. On the right side of the neck, below the posterior part of the right ala of the thyroid cartilage, was some fulness and slight tenderness on pressure. There was no evidence of any nerve lesion. The treatment was iodide of potassium and benzoin inhalations.

On January 19th his condition seemed decidedly better as far as the external fulness was concerned, and he remained in the same state when shown.

The lesion was regarded as an extra-laryngeal infiltration mechanically interfering with the action of the right cord through

involvement of muscle or hindrance of proper movement at crico-arytænoid articulation. This, in spite of its subsidence under iodide of potassium, was regarded as probably tuberculous.

Dr. DUNDAS GRANT considered that the defective movement of the right cord was due to mechanical fixation.

Mr. MILSOM REES thought that the appearance of defective abduction arose from a distortion of the larynx, the epiglottis being twisted.

The PRESIDENT remarked the right cord showed evidence of inflammatory changes; and

Mr. ROBINSON, in reply, said that both cords were congested when the case first came under observation.

TUMOUR OF RIGHT VOCAL CORD. CASE AFTER REMOVAL.

Shown by Mr. H. BETHAM ROBINSON. F. G—, æt. 48, was exhibited at the meeting on June 8th, 1898, with a small sessile swelling on the right cord at the junction of its anterior third with the posterior two thirds. It was convex, of a whitish colour, and compressible. Its removal was advised. This was accordingly done effectively with Grant's forceps under cocaine about ten days later. The tumour was very soft, and smashed up in the forceps, exuding a mucous fluid; thus no microscopical examination could be made. Its nature was either a cyst containing mucus or a myxoma.

The patient had now complete absence of symptoms, and on examination his right cord would be pronounced normal.

The PRESIDENT congratulated Mr. Robinson on the excellent result.

PARALYSIS (? COMPLETE) OF LEFT CORD.

Shown by Dr. FURNISS POTTER. The patient, a man æt. 48 years, came under observation on the 3rd of January last, complaining of hoarseness, which had come on gradually seven weeks previously. History of a "sore" twenty years ago, but none of rash, sore throat, or other sign indicating constitutional infection. Always had good health.

On examination the left cord was seen to be fixed and practically immoveable in a position rather external to a line midway

between the extremes of adduction and abduction. The left side of the soft palate was markedly paretic, there was some diminution of sensation, chiefly along the lower border; the tongue when protruded deviated to the left side; no affection of trapezius, sterno-mastoid, or orbicularis oris. There were slight lateral nystagmoid movements of the eyes; the knee-jerks appeared to respond rather too readily. Examination of the chest gave negative result. Patient had been taking ten-grain doses of iodide of potassium for the last month, but with no appreciable effect.

Sir FELIX SEMON asked why Dr. Potter hesitated to call the case complete recurrent paralysis. He regarded it as a perfect case, the left cord being in the typical cadaveric position.

Dr. HERBERT TILLEY thought that such cases as these tended to uphold clinically what had been experimentally proved by Horsley and Beevor, viz. that the nerve-supply of the palate, contractors of the pharynx, and probably the muscles of the larynx, was the spinal accessory. This was the fourth case of the kind the speaker had seen within two months, and he thought it was very doubtful if the facial nerve innervated the palate at all, as had until recently been taught in our schools.

CASE OF ULCER OF NASAL SEPTUM.

Shown by Mr. BOWLBY. Female æt. 32, married, and with several healthy children. No history of tubercle or syphilis, and no evidence of either. Had some swelling of the septum nasi about a year ago. This remained covered by normal mucous membrane for six or eight months, and recently has become ulcerated. There is now an ulcer about the size of a large pea at the upper part of the cartilage of the septum. It is not painful. There is no bare bone and no other disease of the nose. The ulceration progresses very slowly in depth, and not at all in extent. No tubercle bacilli have been found.

Dr. DUNDAS GRANT considered the perforation more irregular in outline than the typical perforating ulcer, and more suggestive of tubercle or lupus. This idea was confirmed by the patient's tint and the injurious influence of cold weather.

Dr. STCLAIR THOMSON agreed that the ulceration was situated too far in the nose to be a simple traumatic perforation from the irritation of dust or nose-picking. He thought that against the suggestion of syphilis was to be placed the consideration that the disease had lasted

a considerable time without the progress which is to be found in specific affections. The characteristic odour of nasal syphilis was also absent. He thought the indolent thickened margin and the situation both suggestive of tuberculosis. He had shown a similar case at the Clinical Society, where in portions of the removed granulations he had discovered typical giant-cells. In his case it had been objected that tubercle bacilli were not found in the sections, although carefully sought for. But as his patient had been treated with tuberculin and reacted strongly, he thought his diagnosis fully confirmed. Tuberculin might be used in the present case both for diagnostic and curative purposes.

Mr. WAGGETT said that the history of previous bilateral swelling and the presence of the much thickened and inflamed edges differentiated the ulcer in Mr. Bowlby's case from what was generally known as the perforating ulcer. The latter was characterised throughout its course by an atrophic process.

Dr. SCANES SPICER thought that the ulceration was probably syphilitic in nature, in spite of the absence of a characteristic stench.

The PRESIDENT said it was certainly not a case of ordinary atrophic ulceration. He had observed such cases from the commencement, and in one case had been able to predict a perforating ulcer. There was never previous thickening of the mucous membrane, but always atrophy.

SPECIMEN OF ABSCESS OF THE LARYNX.

Shown by Dr. DE HAVILLAND HALL. The larynx shown was removed from a female æt. 17. The patient was admitted into the Westminster Hospital on December 17th, with acute Bright's disease and lobar pneumonia of septic origin. Shortly after admission she became hoarse, and suffered from dysphagia. A satisfactory laryngoscopic view was impossible on account of the patient's condition. She died December 24th. At the necropsy about an ounce of dark green fœtid pus escaped from around the larynx, the cartilages of which were quite necrosed; the abscess had recently perforated the larynx through a small aperture. Both lungs were pneumonic. There were old thin pericardial adhesions. The cardiac valves were normal with the exception of the mitral, round which was a ring of large coarse vegetations. In the right lobe of the liver was a hydatid cyst, the size of an orange, containing hydatid membrane and thick olive-greenish viscid pus. The rest of the liver was febrile. The spleen and kidneys showed the ordinary changes of toxæmia.

INFANT EXHIBITING A PECULIAR GRUNTING INSPIRATORY SOUND.

Shown by Dr. WILLIAM HILL. The noise was practically continuous, being just as well marked during sleep as at other times, but there was an occasional intermission during one or two respirations. The grunt was not affected by retracting the palate, and was, he believed, produced in some part of the larynx and not in the trachea. He had not passed a Schroetter's tube into the larynx, but such a measure would serve to differentiate between a tracheal and laryngeal sound. He thought the case belonged to the group described by Dr. Gee and Dr. Lees, and more recently by Dr. Lack, and he accepted the latter's explanation (which was an amplification of Dr. Lees' theory of the influence of the epiglottis) that the vestibular structures were here exceptionally lax, and collapsed during inspiration. This could be seen by the aid of the mirror. The sound was unlike those produced in the glottic region, and there was no reason to suspect stenosis from paralysis, or from any intra-laryngeal swelling.

The PRESIDENT did not consider the case agreed in all particulars with those described by Dr. Gee as cases of respiratory croaking in infants.

Sir FELIX SEMON thought that in this case the stridor was produced in the trachea, or at any rate below the larynx. He alluded to some recent papers pointing to enlargement of the thymus gland as the possible ætiological factor in such cases. He thought intubation would certainly settle the point as to whether the stridor arose in the larynx.

Mr. MILSOM REES remarked that the stridor ceased when the child cried, and asked if it continued in sleep.

Dr. LACK looked on the case as one of the milder forms of the affection commonly known as congenital laryngeal obstruction, and due, as in all such cases, to collapse of the vestibule aided by curling of the epiglottis. Where there was very marked obstruction the inspiratory sound was "like a chicken crowing," and occasionally associated with slight expiratory stridor. In less marked cases like Dr. Hill's the stridor was of a "purring," "grunting" character, with no expiratory sound. In all cases of tracheal obstruction due to pressure of an enlarged thymus *expiratory* stridor only was present, or at any rate much more marked than *inspiratory*.

Dr. HILL said the stridor continued during sleep. He would give the child chloroform and ascertain if the stridor continued then, and intubate with a long tube so as to exclude a laryngeal origin for the sound. Personally he thought it appeared to arise from the parts above rather than below the larynx.

Case of Papillomata of Larynx.

Shown by Mr. Richard Lake. Patient has been hoarse for five years, but worse since an attack of typhoid fever last year. There is now a large papilloma in the anterior commissure springing from the right vocal cord, and also one of moderate size on the left vocal process.

Man æt. 51, shown at the November Meeting as a Case of Hypertrophic Laryngitis of Doubtful Nature, which is now seen to be Tuberculous.

Shown by Dr. StClair Thomson. The history of this case is described in the 'Proceedings' for November, 1898, p. 2. At that period the patient presented no evidence of pulmonary tuberculosis, and some suspicions were expressed that the case was malignant, and it was advised that a portion of the growth should be removed for microscopic examination. This was done, but with a negative result. The patient was put upon large doses of iodide of potassium. An ulcer, very suspicious of tuberculosis, appeared on the epiglottis, and the patient rapidly wasted. Further examination showed commencing phthisis, and the expectoration, which had previously been absent, revealed numerous tubercle bacilli. The case was now evidently one of tuberculosis, and was shown as illustrative of the difficulties which this affection in the larynx might present. From this point of view the case was similar to the one shown by Mr. Stephen Paget at one of the meetings last year.

Dr. Clifford Beale asked if the œdema occurred suddenly in this patient, remarking that he had commonly observed its rapid onset in similar cases where iodide of potassium was prescribed. Once present, however, it remained, and thus differed from acute œdema.

The President suggested that the iodide could be used like tuberculin, as a diagnostic test for tubercle.

In reply, Dr. StClair Thomson said the development of œdema of the arytænoids was as Dr. Clifford Beale suggested; it occurred quite suddenly in one week.

Large Naso-pharyngeal Polypus.

Shown by Dr. Herbert Tilley. The polypus was removed from a woman æt. 45. The post-nasal space was filled by the growth, and it extended by a nipple-like process below the level of the uvula, producing, especially at night, a feeling of suffocation. It was removed with Löwenberg's forceps, and the resulting hæmorrhage was slight.

Sir Felix Semon inquired if the polypus had undergone cystic degeneration. In his experience, almost all nasal polypi which protruded into the post-nasal space contained larger or smaller cysts, whilst such were not nearly so frequently found in the myxomatous polypi situated in the nose itself.

Dr. Hill thought this was, properly speaking, a case of nasal, and not post-nasal polypus, the growth apparently arising from the interior of the nose. Further, he objected to the term myxoma being applied to nasal polypi.

Sir Felix Semon said he had used the term inadvertently from old custom.

Dr. Lack said he had quite recently removed a nasal polypus protruding both from anterior and posterior nares, and very firm, with no cystic degeneration. The specimen was very similar to Dr. Tilley's in shape and size.

Dr. Spicer agreed that nearly all polypi springing from both anterior and posterior ends of the middle turbinate contain cysts, often eight to ten small ones. He suggested that large cysts are often dilated ethmoidal cells.

Mr. Waggett wished to corroborate Sir Felix Semon's statement that cysts were generally evident in polypi removed from this position. Moreover small glandular cysts were to be found in the large majority of all nasal polypi.

In reply, Dr. Tilley said that he removed the polypus with Löwenberg's forceps passed into the post-nasal space. He had used the term naso-pharyngeal in an anatomical sense, and not as indicative of the pathological nature of the new growth. The polypus contained one or two large cysts, and measured five inches in its longest and three and a half inches in its shortest diameter.

Epitheliomatous Ulceration of Naso-pharynx.

Shown by Dr. Herbert Tilley. Patient is a man æt. 55. He complains of difficulty in breathing through the nose, and an unpleasant discharge into the mouth, also general weakness.

The palate is seen to be immobile and almost vertical in direction, obviously due to something in the post-nasal space. Its free borders are so thickened and congested that only a small aperture just sufficient to admit the index finger to the naso-pharynx is present. On introducing the finger the ulceration is very evident, and the discharge peculiarly offensive, reminding one of that which is so characteristic of advanced epitheliomatous disease of the tongue. There is an enlarged gland under the upper part of the left sterno-mastoid. A mixture of iodide of potash and mercury perchloride during the last week has had no visible effect on the disease.

Dr. StClair Thomson had had a similar case in a patient æt. 34. He had considered it a case of late adenoids, although the growth appeared rather congested. Operation was attended with profuse hæmorrhage. Patient was seen a few months later with recurrence of growth and enlarged glands in neck. He died shortly after, and the diagnosis of epithelioma of Luschka's tonsil was confirmed by necropsy and microscopical examination.

Mr. Milsom Rees had recently had a similar case.

Case of Empyema of the Antrum cured by Alveolar Irrigation after Failure of Intra-nasal Treatment.

Shown by Dr. Dundas Grant. In this case an endeavour had been made to treat the condition by irrigations by means of cannulas introduced into the antrum through the inferior meatus according to Lichtwitz's method, but without bringing about any continuous cessation of the discharge. The condition obviously arose from disease of several teeth, the stumps of which were thoroughly removed. The alveolar puncture was then resorted to, and the patient irrigated her antrum night and morning without difficulty, with the result that extremely rapid improvement took place, and there was every prospect that eventually a cure would be effected. Dr. Grant brought forward this case to show that his advocacy of intra-nasal methods did not prevent him from recognising the value and unequalled convenience of the alveolar puncture in suitable cases.

Sir Felix Semon thought the Society should be very grateful to Dr. Grant for bringing this case forward, as a contrast to the one

shown at the last meeting. Sometimes one method, sometimes another, was to be preferred; tnere was no royal road to success.

Dr. HILL and the PRESIDENT suggested this case was of dental origin, and therefore alveolar puncture was successful when intra-nasal failed.

In reply, Dr. GRANT stated that he had in that Society formulated the proposition that antral empyemata of dental origin should be treated through the alveolus, those of other origin through the nose.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

48TH ORDINARY MEETING, *March 3rd*, 1899.

F. DE HAVILLAND HALL, M.D., President, in the Chair.

WILLIAM HILL, M.D., LAMBERT LACK, M.D., } Secretaries.

Present—27 members and 1 visitor.

The minutes of the previous meeting were read and confirmed.

The following gentlemen were unanimously elected members of the Society:

Mark Purcell Mayo Collier.
St. George Caulfield Reid.
H. Fitzgerald Powell.

The following gentlemen were nominated for election at the next meeting:

Henry J. Davis, M.B.Camb., M.R.C.P.London.
Peter Abercrombie, M.D.Glasgow.
Alfred B. Lazarus, M.B., C.M.Edinburgh.

The following cases were shown:

CASE OF LARYNGEAL PARALYSIS SECONDARY TO STRICTURE OF THE ŒSOPHAGUS.

Shown by Mr. BOWLBY. Man æt. 50. Suffers from difficulty in swallowing and loss of voice. His symptoms began

twelve months ago, when he had a very slight difficulty and pain at about the middle of the sternum on swallowing. Six months ago he suddenly lost his voice, and has had partial aphonia ever since. Swallowing has gradually become more difficult, and for three months he has been unable to take anything more solid than soaked bread.

Present condition.—On the left side of the neck there is some fulness, and a mass of hard, matted lymphatic glands can be felt reaching from the clavicle upwards to the level of the cricoid cartilage. On passing an œsophageal bougie a stricture can be felt at a distance of seven inches from the teeth. Laryngoscopical examination shows that the larynx is natural, except that the left vocal cord is fixed in a position midway between abduction and adduction. In front of the processus vocalis the free edge of the left cord is concave. Nothing abnormal in the chest. Pulses equal. Pupils equal.

I have seen paralysis of the vocal cords in cases of œsophageal stricture on several occasions, the left cord being more often involved. I think it may be compressed either by the original growth or by enlarged and infiltrated glands. In the present case the concavity of the cord is very marked, a condition probably due to paralysis of the internal tensor.

Dr. Clifford Beale described a case he had just seen which was almost similar, but at a somewhat more advanced stage. The patient had been for some time under observation, the first evidence of mischief being obstruction of the larynx. On the left side of the trachea there was a swelling which was acutely tender. Under large doses of iodide of potassium the swelling had considerably diminished, and the pain absolutely disappeared. The larynx showed complete abductor paralysis, the cords lying in the cadaveric position. When first seen she spoke with a clear voice. As the patient was subject to adductor spasm, tracheotomy had to be performed. It was now possible to examine freely, and all down the neck on the left side of the œsophagus a hard infiltration could be felt. Under chloroform the top of the growth could be made out with the finger. There was no evidence to indicate how long the paralysis of the cords had lasted, as the voice had not been affected, and up to the time he had first seen her there had been sufficient breathing space.

Sir Felix Semon would not undertake to say off-hand whether, in his experience of œsophageal stenosis, the right or the left vocal cord was more frequently affected, but he could recall several cases of œsophageal obstruction in which the right vocal cord had been paralysed. It was possible that the latter cases made a greater impression

on their minds, since in cases of left-sided paralysis an aneurism was more often the cause than œsophageal mischief. With reference to the flaccid and excavated appearance of the left vocal cord, and the question whether that was due to participation on the part of the superior laryngeal nerve, or whether implication of the recurrent was alone sufficient to explain it, he believed that the latter fully sufficed, because, if the internal tensor became paralysed, the result, in his experience, was the excavated and flaccid appearance of the vocal cord exhibited by Mr. Bowlby's patient. It has been recently stated that if the recurrent laryngeal nerve was completely paralysed, the crico-thyroid muscle would, being no longer opposed by any antagonistic muscle, from mere inactivity undergo degeneration and atrophy. This statement, he was convinced, was purely theoretical. He need only point to cases of abductor paralysis in tabes, such as shown in this Society, in which the affection had lasted for ten or more years, and yet the patient had been able not only to speak with a perfectly normal voice, but even to sing. If that period was not sufficient to produce paralysis of the crico-thyroid from inactivity, he wondered what time was required for the purpose. Besides, Dr. Friedrich, of Leipzig, and Dr. Herzfeld, of Berlin, had found on post-mortem examination the crico-thyroid perfectly normal in cases of complete and long-standing recurrent paralysis. He would suggest that every opportunity be seized in such cases of making a post-mortem examination and instituting a thorough macro- and microscopic examination of the crico-thyroid, and publishing the results of the observation.

Dr. DE HAVILLAND HALL could see no anatomical reason why, in cases of malignant disease of the œsophagus, one vocal cord should be more frequently affected than the other. He thought he had himself seen more cases of right than of left-sided paralysis, but, as Sir Felix Semon had remarked, right-sided paralysis probably made more impression on their minds than left-sided, which was so comparatively common that they were not surprised to find it, whereas a case of right-sided paralysis put them on the *qui vive* to ascertain its cause. As for the place of involvement of the nerve, he found that on pressing the enlarged gland of the neck the man had a distinct attack of spasm of the glottis, and there was marked stridor. This, he thought, the left cord being paralysed, must have been through the afferent fibres and down the vagus on the right side.

CASE OF LUPUS OF NOSE.

Shown by Dr. EDWARD LAW. Female, æt. 33, came to the hospital three years ago suffering from lupus of the skin of the left ala nasi, with a few granulations inside the nasal orifice. Perfect cicatrisation took place after scraping, &c., and no recurrence was noticed for eighteen months, when granulations appeared on the floor of the left nasal fossa and extended up to

the middle turbinal, with nodules on the posterior margin of the septum. Curetting, and applications of lactic acid brought about a satisfactory result, and the patient was discharged apparently cured. A few weeks ago, a posterior rhinoscopic examination revealed a small swelling in the soft palate, immediately behind the posterior margin of the septum.

Case of Nasal Polypi complicated by Well-marked Bilateral Septal Obstruction.

Shown by Dr. Edward Law. Patient, æt. 31, came under observation at the end of last year on account of difficulty in nasal respiration, one or other side being constantly blocked. There is a history of the nose having been broken whilst playing football sixteen years ago, and of a similar accident five years ago, "when there was some difficulty in keeping the three pieces in their proper position."

Examination showed an irregularly deflected septum, with well-marked bilateral prominences at the lower margin of the nasal bones, and an unusually large, long, and thick spur running parallel to, and in union with, the inferior turbinate on the left side. The whole septum is much thickened, and there are polypi in each nasal cavity behind the obstructions. At first it was impossible to obtain a posterior rhinoscopic image on account of the great irritability which accompanied the naso-pharyngeal catarrh. This disappeared after the discontinuance of tobacco, malt liquors, and attention to diet, &c. The posterior extremities of both inferior turbinals are somewhat hypertrophied. The case is interesting, and the opinion of members is requested as to the methods and extent of operative interference.

A discussion ensued on operative interference in cases of stenosis of the nose in general.

Sir Felix Semon said he had recently had a series of cases in which the tendency to adhesion, which was so marked a peculiarity after operations in the nose, had been even more prominent than usual. In one case in which he had removed, by sawing and cutting, a projecting part of the turbinate bones and the septum, every means

he had tried to keep the passage open had failed. The patient had been unable to bear plugging with gauze or wadding; neither could she stand gutta percha, celluloid, or silver. Ivory was the only thing she could bear. He had tried every astringent and sedative he knew of, and had employed cocaine so as to contract the mucous membrane. Nothing availed; everything irritated and gave pain; and each time the plugging was left off adhesions formed. He had sent the patient to her home, and there the parts grew together again, so that he had anew to operate. She was now wearing an ivory plug. When it was taken out she breathed as freely through one nostril as the other, but, although there was a distance of 2 mm. between them, the opposite surfaces touched and united when the plug was left out for six hours. He would like to know if anyone could suggest what to do in such a case. At present he was merely applying pure paroleine, and there was no pain now.

Dr. WILLIAM HILL said that within the last few months he had operated on a case seven times. First he had cut away a piece of the turbinal and a small bit of septum. On removal of the plug, a clot or a scab would form and a bridge appear. In this case he had cut with scissors the turbinal on the outer side, and destroyed the bridge quite six times. He had used the soft rubber plug, which he believed was least irritating, though not very aseptic, and it had been borne well. He believed that if they simply went on persistently with a suitable plug, healing must in course of time occur.

Dr. WAGGETT said he had had a similar case that gave great trouble. He had come to the conclusion that the prolonged use of plugs after operation was disadvantageous, in that it caused a local anæmia of the injured parts and prevented healing. The parts could be kept asunder without pressure by inserting a sheet (not a plug) of celluloid, which took up little room and left quite enough space for the escape of discharge from the surfaces of the ulcers. The celluloid should be removed daily, and the nose syringed.

Mr. SPENCER said it was the continuance of the local treatment that was the difficulty, owing to the pain caused, especially in the hyperæsthetic cases. In Dr. Law's case there were two very thick ridges of half cartilage, half bone, close down upon the floor of the nose. To treat such a case by Bosworth's saw on either side would be exceedingly difficult, the nose was so narrow. Every case should be treated, if possible, under cocaine, but there was a more complete method of treatment, namely, to remove, under an anæsthetic, the whole of the inferior turbinal, either by knife or scissors, and at the same time, if the nose were excessively narrow, to dilate it till it was thoroughly free Dr. Hall had sent a young man to him in whom there was marked hyperæsthesia. The anterior part of the inferior turbinal had been removed by a practitioner, but an adhesion to the septum had formed. A plug had been put in, but the pain prevented its retention. Under a general anæsthetic, the whole inferior turbinal bone was removed, the nose was plugged for a day, then douched, and under this treatment had healed, leaving a free passage.

Dr. SCANES SPICER said he felt sure Dr. Law's case was one of those in which, having obtained permission to remove whatever was necessary

to radically clear the nasal obstruction, a general anæsthetic should be given and the thing done thoroughly. It might be necessary to remove the spurs on both sides and to tackle the middle (for the case was complicated with polypi and purulent sinusitis) as well as the inferior turbinates. That, of course, would mean ten days or a fortnight's confinement to hospital; but such a case as this was best and quickest treated in this radical fashion. Referring to Sir F. Semon's case, of late years he had had no troublesome adhesions after nasal operations until last December, when, through not continuing long enough personal attention to the nose, he had seen two. One patient, having been in London for ten days, was allowed to return home too soon after operation; a "cold" supervened, a bridge formed, and she had to return to London, and it took over a fortnight to conquer the bridge. In the second case exactly the same thing happened. He had worked at this case for two months, and the patient was not yet out of the wood. In obstinate and irritable cases he believed the proper plan was to give the patient a complete rest and allow the bridge to consolidate, simply lubricate with soothing unguents, and get all inflammation down; then, later, attack the non-inflamed bridge. In such a case as Sir Felix Semon had described, a temporary policy of masterly inactivity, such as recommended, would in the end prove most efficient and shortest. It was possible that in these cases freer removal of adjacent parts should have been done, and would have prevented this bridging. For his own part the speaker felt his errors had been invariably in the direction of removing too little rather than too much.

Dr. DE HAVILLAND HALL said that nothing short of the heroic measures taken in the case instanced by Mr. Spencer would have succeeded, the condition being one of long adhesion in narrow nostrils. The result was exceedingly satisfactory.

Dr. DONELAN said he had had much trouble with an adhesion associated with a good deal of hyperæsthesia. There was eczema of the auditory meatus, for which he was using Burow's solution of acetate of lead and alum. He at last tried this in the nose, separating the adherent surfaces with lint soaked in it. The hyperæsthesia was at once relieved, and the adhesion was soon overcome. He further referred to the occasional ill effects of turbinectomy, and mentioned a case in which necrosis of the upper jaw and facial paralysis had followed that operation.

Dr. DUNDAS GRANT said that he had performed inferior turbinectomy for the purpose of getting rid of an adhesion with satisfactory result; but in one case, where there was no previous adhesion, plugging after complete removal of the inferior turbinate body was followed by such inflammatory reaction that an adhesion formed. In one case of adhesion between the left turbinate and the septum in a medical man he had removed the anterior extremity of the turbinate; but that did not prove sufficient. The patient then asked him simply to remove the band, and he would try to keep it open by means of a nasal bougie made of the silk-wove material used in urethral bougies. This the patient cut short, and went about with it *in situ* all day. He was now cured. It was sometimes a question whether adhesions required to be

interfered with. In a case in which the nasal obstruction was so marked that he could only remove the polypi at the posterior part after sawing away a spur on the septum, an adhesion formed which seemed to cause no discomfort, and the relief from the partial operation was so great that he was exercising a "masterly inactivity." Use of cocaine had two effects, anæsthetisation and contraction. But a spray of 4 per cent. of antipyrin would bring about contraction of longer duration. It was, however, rather irritating, and he preceded it by a spray of 5 per cent. eucaine. With that combination an enormous amount of comfort was afforded without risk. In reply to a remark by Mr. Atwood Thorne, that bridges did not seem to him to form unless both terminal and spur were operated on at one time, and his suggestion that they should be dealt with at different times, Dr. Grant replied that there had been cases of adhesion which had arisen without any operative interference at all.

Dr. Edward Law, in replying to the discussion, said that unless the adhesion mentioned by Sir Felix Semon was a very broad one, he should certainly let it heal, and not tamper with it for six or twelve months. One had occasionally to break down adhesions in order to pass the Eustachian catheter, and he had been surprised at the ease with which the surfaces could be kept apart compared with the adhesive tendency manifested after any operations in the nose. This freedom from adhesion in the case of the division of bridges of long duration was probably accounted for by the adjacent mucous membrane being in a more or less normal condition.

Case of Complete Adhesion of the Soft Palate to the Posterior Wall of the Pharynx.

Shown by Dr. de Havilland Hall. The patient, a married woman of 33, was quite unaware of her condition until informed of it, but she noticed that she could not blow her nose like other people. She has never suffered from sore throat or skin affection. The left central incisor, upper jaw, is notched and pegged. Eyes not affected. Patient had one child 12 years ago, and has had no miscarriage. She is an only child, and states that her mother had miscarriages. The case is clearly one of inherited syphilis.

Foreign Body impacted in the Naso-pharynx for Four Years.

Shown by Dr. D. R. Paterson. This was a metal regulator for rubber tubing frequently used with infants' feeding bottles.

It was removed from a child aged six years, who came with the history of otorrhœa of the left side and fœtid discharge from the left nostril. There was inability to breathe freely through the nostrils, and something could be distinguished in the posterior nares on looking through the left nostril. Under an anæsthetic a hard mass was felt above the soft palate, fixed immediately behind the posterior choanæ, and on removal was found to be the foreign body thickly coated with phosphates. A history was obtained that when the child was fifteen months old, and was playing with a regulator, it suddenly showed difficulty of breathing, which was relieved by suspending with head downwards, though from that time the nasal breathing became obstructed and the child suffered in health. At various times bougies were passed by different medical men into the œsophagus with a view of disabusing the parents of the notion that there was a foreign body in the throat, and it was for relief of the aural and nasal trouble that advice was lately sought.

Mr. PARKER related what might be called a surgical freak. A boy had come to him complaining of obstruction of the nose. By the aid of the posterior mirror he saw a large grey mass in the posterior nasal space, but, unable to determine what it was by inspection, he had put his finger up. This did not reveal the nature of the body; but just then the boy gave a great heave, and from the back of his nose came a piece of drainage-tube about two inches long and half an inch in diameter. The boy had had an abscess in his neck two years previously, in connection with which the drainage-tube had been used.

CASE OF LARYNGEAL VERTIGO.

Mr. ATWOOD THORNE showed a man, æt. 51, who came to Dr. William Hill at St. Mary's Hospital, on January 5th, 1899, complaining that "whenever he had a fit of coughing he felt giddy and lurched towards his right front." He has been subject to paroxysms of coughing on and off for two years, but the condition has been getting worse lately. He has never fallen, but has to catch hold of something to prevent his doing so.

He is slightly deaf, and for the past two months has had noises "like heavy traffic" in his head.

He has polypoid hypertrophy of both middle turbinates, some lymphoid hypertrophy at the base of the tongue, and some

slight swelling in the interarytænoid space. There is some pulmonary emphysema. No other cause for vertigo being ascertained, the case is brought forward as one of laryngeal vertigo.

Fifteen minims of dilute hydrobromic acid have been given three times a day, and the man describes himself as rather better.

While at the hospital the man has never had an attack, forced coughing not having affected him in any way.

Dr. LAW thought it was possibly a case of *aural* vertigo. The patient complained of deafness and tinnitus; the tympanic membranes were retracted. He thought that catheterisation would reveal the Eustachian tubes to be over patent. The man had probably for some time given his ear repeated concussions either by coughing or blowing his nose. He should be recommended not to blow his nose violently, and some remedies should be given to relieve his cough.

Dr. HILL said the man had been under him for aural treatment. He at first had assumed the case to be one of aural vertigo, but finding the patient had signs of exhaustion sinusitis before one of the attacks, he then was inclined to think it was a case of *nasal* vertigo. Afterwards it was found that the attack *always* came on in connection with some laryngeal irritation and cough, and narrowed down in that way; he believed it was really an instance of laryngeal vertigo.

Dr. DUNDAS GRANT said although the theory of aural vertigo had been propounded by some authors, he was indisposed to accept it, if only because of the extreme rarity with which vertigo followed inflation of the middle ear, a result he himself had never seen. In a case of very definite laryngeal vertigo, or rather syncope, as it was better called, there was a strong gouty tendency, after treatment for which he believed the vertigo disappeared.

Dr. STCLAIR THOMSON suggested that it might be *cardiac* syncope. The patient's pulse was very small and quick, and slightly irregular. The man himself said that when he bent forward to lace his boots he felt inclined to fall on his nose.

CASE OF TUBERCULOUS INTERARYTÆNOID GROWTH.

Shown by Mr. J. S. LUCAS for Mr. Lake.

The patient, a female æt. 33, has been hoarse for four months. For the last eight weeks she has been under treatment, and the throat has been painted with formalin in 3 per cent. solution. She has improved greatly, but still complains of pain if the throat is not painted daily. The swellings in the interarytænoid region are rather unusual, being very irregular.

Two Cases of Extra-laryngeal Cyst.

Mr. Waggett showed two young men exhibiting cystic formations in the thyro-hyoid region.

In the one case a cyst the size of a hazel-nut was found lying upon the thryo-hyoid membrane on the left side. In the second case a tumour, partly cystic, and about the size of a walnut, was present on the left side over the thyro-hyoid membrane and extending down over the corresponding ala of the thyroid cartilage. This was probably a cyst developed from the pyramidal lobe of the thyroid gland.

Mr. de Santi thought the first case a bursal cyst, extra-laryngeal and unconnected with the thyroid. It might be necessary to make a deep dissection, but he thought Dr. Waggett could cut down and remove it. He could not get "blowing out."

Dr. StClair Thomson asked whether the possibility of so-called pneumatocele had been considered, as the tumour could be distended by blowing with closed lips.

Mr. Waggett had at first considered the second case to be one of pneumatocele. He had, however, convinced himself that the slight enlargement which occurred on coughing was due to venous engorgement. On external pressure a slight prominence occurred in the region of the left aryepiglottic fold, but it was quite impossible to cause any diminution in the size of the tumour by prolonged manipulation. He felt certain that the cyst in no way communicated with the lumen of the air-passages. Mr. Waggett agreed with Mr. de Santi in thinking the first case to be one of bursal cyst. As it caused no inconvenience he did not propose to operate.

Case of Multiple Laryngeal Papillomata in a Child æt. 3½ Years, completely removed in three sittings by Endo-laryngeal Method under combined General Anæsthesia and Local Cocainisation, and without Tracheotomy. Result: Full Restoration of Voice and Normal Breathing.

Dr. Scanes Spicer showed this case. Boy, æt. 3½, lost his voice after a cold at the age of seven months, and has always spoken since in a breathy whisper; there is no sound in his laugh or cough, and his breathing is noisy, especially at night. He is highly intelligent, but shy, and can say anything

in his peculiar whisper. His tonsils are enlarged, and there is post-nasal adenoid hyperplasia. Laryngoscopic examination not practicable without anæsthetic.

February 1st.—Dr. Fred. Hewitt administered gas, ether, and chloroform, and patient was placed in intubation position in nurse's lap. The condition was:—Large median, cauliflower mass, whole length of glottis, flapping freely in air current, and attached somewhere on right side; right cord embedded in multiple, pale, warty growths; left cord perfectly healthy and mobile. The median mass only was removed by antero-posterior cutting forceps, as the larynx was irritable, and preparations had not been made to tackle the growths on that occasion.

8th.—No return of voice, but breathing much quieter, especially at night. Anæsthetic was given again as before, and the larynx was sponged with a few drops of 20 per cent. cocaine solution, and well mopped out. This was done two or three times until the larynx was tolerant of the probe and forceps. Eight or ten large clusters of growths were then removed, blood being mopped away at times. After this the tonsils and adenoids were removed.

16th.—The patient still speaks in a whisper, but there is sound in the cough and laugh. Anæsthetic given again and cocainisation as before. Small growth removed and larynx seen to be absolutely free. Recovering from anæsthetic a curious croupy inspiration was observed, which was especially marked when anyone was in the room, but subsided when patient was left alone. The sound of voice did not return for some days, and only gradually. Apparently determined effort was requisite to produce the voice, and it had a raucous, monotonous character devoid of inflexion.

This case is interesting as a further proof of the practicability of removing laryngeal growths in young children by the method described by the writer some years ago. He then had had four such cases, later one more, and, until the present one, no case of the kind for five years. This case has been far more rapid than any of the others, and the operator has been much indebted to Dr. Hewitt for many suggestions in connection with the anæsthetic and position. It is also a point of much interest that the

voice did not return at once, though there was no mechanical impediment to adduction. This might have been due to slight bruising during operation, or it might have been a result of the threefold co-ordination of breath, articulation, and adduction never having been established at the time when the child lost its power of adduction.

Sir FELIX SEMON thought the result most satisfactory, and one upon which Dr. Spicer ought to be congratulated. He had himself seen the child before the operation. It was then in a very bad condition, perfectly aphonic, and with loud laryngeal stridor, and a suggestion of tracheotomy had been made.

Dr. WILLIAM HILL said Dr. Spicer's results put the question of treatment of papillomata in children of three or four years of age on quite a new basis. Instead of putting off operation till the patient was seven or eight, Dr. Spicer cleared out the larynx at any age. He had himself seen two cases in which the finger nail was used at his suggestion to remove some of the growths.

Dr. SCANES SPICER said the growths were removed under the guidance of the mirror. The longest time occupied at a sitting in his earlier cases was two hours. There was a good deal of trouble in connection with the chloroform. Very little cocaine solution was used. He followed up the spray immediately with a dry cotton-wool mop, giving it a brisk turn round so that no cocaine was swallowed, and a local anæsthetisation was thus procured, which supplemented the chloroform and allowed the field to be operated on without exciting reflex contraction and closure. In the present case Dr. Frederic Hewitt had given the chloroform, and had much facilitated the operations.

CASE OF PACHYDERMIA OF THE LARYNX, PROBABLY DUE TO CHRONIC RHINITIS.

Shown by Dr. DUNDAS GRANT. Man, æt. 21, was first seen by Dr. Grant on the 25th February, when he complained of huskiness of the voice which had persisted for two months subsequent to a cold, also frequent coughing and hawking. He attributed the condition to an attack of diphtheria nine years before. It appeared that on at least two occasions such hoarseness had followed colds and had lasted for several months. On examination of the larynx there was found a dry congestive condition of the vocal cords, with a pale irregular fringe on both vocal processes. The thickness on the vocal processes was

irregular, and the processes appeared on phonation to dovetail into each other.

In the nose there was hypertrophy of the inferior turbinated bodies and increased muco-purulent secretion. There was no history of specific disease nor of excessive use of the voice. The patient is otherwise in excellent health, and the condition, if not absolutely typical of pachydermia, seems to approximate to it extremely closely. The treatment proposed is the removal of the hypertrophied portions of the inferior turbinated body and application of the alcoholic solution of salicylic acid to the larynx.

Dr. DE HAVILLAND HALL doubted whether the case could be called one of pachydermia. It did not extend far enough along the processus vocalis. He had seen pachydermia in alcoholics who were also voice users. Sir Felix Semon having remarked that he had seen it most frequently in clergymen, Dr. de Havilland Hall further remarked that one of his cases was that of a clergyman in whom lipomata on the nape of the neck had led him to suspect alcoholism.

Dr. DUNDAS GRANT thought his case approximated closely to pachydermia, though not of the typical shirt-button type, and was a hyperplasia of the epithelial tissue.

CASE OF PAPILLOMA OF THE LARYNX PREVIOUSLY SHOWN IN AN ELDERLY MAN. COMPLETE REMOVAL.

Shown by Dr. DUNDAS GRANT. Man, æt. 60, came under my care on the 28th October on account of hoarseness and loss of voice of a year's duration. The growth in this case was removed by means of Grant's forceps, and on microscopical examination presented the characteristics of a soft papilloma. The stump underwent some regrowth, but the alcoholic solution of salicylic acid was applied and the forceps again used, leaving only a slight roughness on the site of the growth. This was treated with local application of salicylic acid two or three times a week, and at present the voice has reached its normal condition; the edge of the cord is nearly smooth, though its colour is still abnormally red.

Case of Multiple Papillomata.

Shown by Dr. Dundas Grant. A woman æt. 59 came under my care on February 23rd on account of hoarseness and loss of voice of two years' duration. On the edge and upper surface of the right vocal cord was a sessile mass of a soft, warty appearance, which was, from its mobility, apparently of soft consistency, the papillation of the surface being particularly marked. This extended to the anterior commissure, where there was a roundish outgrowth. The left vocal cord was reddish and irregular at its edges, but was partially concealed by the growth from the other side. The movement of both sides of the larynx appeared to be normal, the voice was almost lost, and was more whispering than hoarse. By means of Grant's forceps a large portion of the growth was at once removed, but no particular effect on the voice was produced. Three days later, further removal was effected by means of the same instrument, but the growth at the anterior commissure could not be reached, probably on account of the length of the beak of the forceps employed. This was, however, removed completely by means of MacNeill Whistler's forceps. On the 1st of March the larynx was free from any large mass of growth. There still remained a slight fringe on the right cord, and there was seen below the middle of the left one a pale smooth sessile growth of very small dimensions. A 5 per cent. solution of salicylic acid was then applied between the cords. At this date the voice seemed as toneless as ever, but with a little insistence the patient was induced to utter hoarse but fairly loud sounds. It seemed as if the habit of whispering had become established, and that even after removal of the new growth in the larynx this would have to be overcome by practice.

Case of Large Gumma in Posterior Pharyngeal Wall.

Shown by Mr. Arthur Cheatle. A woman, æt. 37, came to the Royal Ear Hospital ten days ago, complaining of difficulty of swallowing, and "a lump" in her throat. A smooth swelling,

an inch and a half in breadth, situated slightly to the left of the middle line, reached from high up in the naso-pharynx downwards to the level of the top of the larynx. It was soft and fluctuating in the centre, hard at the edges, where it faded into surrounding parts. There was a history of numerous miscarriages and some stillbirths. Resolution was taking place under iodide of potassium and perchloride of mercury.

Case of Fixation of Left Vocal Cord with Fibrillar Movements.

Shown by Mr. W. G. Spencer. The patient, æt. 62, served in the navy, but having suffered from repeated attacks of rheumatism, he was invalided. His voice has not been good for years, and he has had attacks of aphonia. During the last four months he has been very hoarse or completely aphonic. The left vocal cord is fixed as regards voluntary movements. The arytænoid cartilage is fixed and drawn forwards, forming a ridge. The cord itself is unaltered, but continually exhibits fibrillar movements. Some congestion of the larynx has become less under treatment.

Dr. Herbert Tilley suggested that the curious appearance presented was due to tilting and fixation of the arytænoid cartilage, and that there might be some trouble (possibly rheumatic) in the crico-arytænoid joint. The twitching movements of the tissues covering the fixed arytænoid reminded him of a similar condition seen in a case of syringomyelia, with palatal and left abductor laryngeal paralysis, shown to the Society by Dr. Horne (June 9th, 1897).

Sir Felix Semon referred to a former paper of his on the subject, which described a case in which there was also complete tilting of the arytænoid cartilage, with fixation of the cord and the formation of a ridge in consequence of the drawing of the parts. In that case there appeared to be congenital anchylosis and luxation of the crico-arytænoid joint.

Case of Recurrent Papillomata of Larynx.

Shown by Mr. C. A. Parker. The patient, a man æt. 25, was first seen three years ago, when he had been hoarse for four months. The larynx was then found to be almost entirely filled

with papillomatous growths. The growths were removed, with great improvement to the voice. At intervals of a few months the patient has returned with recurrence of the growths, which have been removed on about twelve occasions. The patient has not been seen until now for fourteen months. The voice is impaired, and he has pricking pain on swallowing. The whole of the anterior part of the larynx seems to be filled up with growths, the posterior wall alone is free.

A Skiagram of Foreign Body in the Œsophagus.

Mr. de Santi showed a skiagram of a halfpenny tightly wedged in the œsophagus, opposite the level of the top of the sternum.

The patient was a child of 2 years 11 months, who had swallowed a halfpenny eleven days before Mr. de Santi saw him.

The mother of the child stated she had carefully examined the stools passed, but had seen no halfpenny. Beyond having occasional attacks of vomiting there had been no symptoms.

When brought to Mr. de Santi the mother stated the child complained of pain in the right iliac fossa. On examination the child cried on that locality being pressed.

Mr. de Santi ordered the air-passages to be skiagraphed. The halfpenny was then clearly seen in the œsophagus. Under chloroform the top of the coin was with difficulty felt with the tip of the index finger. It was extracted by means of the coin-catcher, although tightly wedged.

The child made an uninterrupted recovery. The interest of the case lay: (1) in the length of time the coin had remained impacted in the œsophagus, *i. e.* twelve days; (2) the absence of any localising symptoms, such as pain, dysphagia, or dyspnœa; (3) the presence of pain around cæcum, suggesting lodgment of the coin in that neighbourhood; (4) the absence of any inflammation or ulceration in the neck where the coin was wedged.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

49TH ORDINARY MEETING, *April 7th*, 1899.

A. BOWLBY, Esq., F.R.C.S., in the Chair.

WILLIAM HILL, M.D., LAMBERT LACK, M.D., } Secretaries.

Present—22 members and 5 visitors.

The minutes of the previous meeting were read and confirmed.

The following gentlemen were unanimously elected members of the Society:

Henry J. Davis, M.B.Camb., M.R.C.P.Lond.
Peter Abercrombie, M.D.Glas.
Alfred B. Lazarus, M.B., C.M.Edin.

The following cases and specimens were shown:

CASE OF PACHYDERMIA LARYNGIS.

Shown by Mr. C. A. PARKER. A. C—, male, æt. 32, was first seen five years ago, suffering from well-marked and typical pachydermia laryngis, the greater swelling being on the right vocal cord. At first it yielded to none of the ordinary methods of treatment, but finally it was reduced by means of electrolysis, small portions also being removed by means of forceps. Two

years ago the pachydermatous swellings had almost entirely disappeared, and the voice had much improved, but considerable general thickening of the larynx remained. Since then he has had several attacks of laryngitis which have yielded to treatment. Three months ago, however, he returned with a marked pachydermatous thickening on the posterior third of the right vocal cord and a corresponding swelling on the left. This is again yielding to astringent applications locally, and iodide of potassium internally, but it is still well marked, and there is a great amount of general thickening of the mucous membrane of the whole larynx with laryngitis.

There is no history of syphilis. He drinks about one pint of beer a day, and he does not use his voice to any unusual extent. As a boy, up to the age of seventeen years, he sang in a choir, and was able to take very high notes.

The long duration and the obstinacy of the case led me to bring it before the Society in the hope of suggestions as to future treatment.

Case of Paresis of the Right Vocal Cord.

Shown by Dr. StClair Thomson. When the title of this case was sent in to the Secretary the right cord was perfectly fixed in the cadaveric position. It was now seen, however, to be moving fairly well. The case was interesting from the variability of the symptoms. The patient was a man aged thirty-four, who contracted influenza last autumn, and has been hoarse since November. When first examined in January last he was seen to have paresis of both internal tensors. This was confirmed at a second visit, and by several observers. At the end of a few weeks, although the patient felt his voice stronger, there was found to be complete abductor paralysis of the right vocal cord. There was nothing to account for this in his neck, chest, or general symptoms.

There was no history of syphilis, but as his wife had had several miscarriages he was put upon specific treatment. The laryngeal condition improved at first, then relapsed, and was now again rapidly improving.

Mr. BOWLBY mentioned the case of a gentleman, æt. 48, who after influenza nearly lost his voice and had attacks of difficulty of breathing, having to gasp for breath after coughing. Examination revealed paresis of the abductors of both cords. At the end of three months this condition gradually passed away under no special treatment, and the patient had since been perfectly well. Paresis of some of the muscles of the larynx was not a very uncommon thing.

SPECIMEN OF LARGE THYROID CYST.

Shown by Dr. HERBERT TILLEY. The cyst measured ten and a half inches in circumference, and weighed eleven and a quarter ounces. It was removed from the left lobe of the thyroid gland in a female, aged thirty-five, who was suffering from difficulty of breathing owing to displacement of the trachea to the right.

SPECIMEN OF OLD-STANDING BRONCHOCELE, BECOMING MALIGNANT AND CAUSING PRESSURE ON THE ŒSOPHAGUS AND TRACHEA.

Shown by Mr. DE SANTI. The patient was a woman æt. 60, and had had a bronchocele for some twenty years. For a few weeks before applying to the hospital she had had dyspnœa which increased and caused much trouble. On examination a large fibrous bronchocele was found; there was marked inspiratory dyspnœa, and no view of the larynx could be got. The bronchocele not only extended laterally, but also downwards behind the sternum. It had not increased much latterly.

A median incision was made and a large part of the centre of the tumour removed. This gave complete relief for eight months. The growth microscopically was benign.

The patient was readmitted for severe dyspnœa and dysphagia eight months after the first operation, and some more of the thyroid was removed. The trachea was not seen. Relief was obtained, but the patient died three weeks later from sudden cardiac syncope.

The specimen showed that the trachea was much deflected to the right, and was not only scabbard shaped but also flattened antero-posteriorly. The œsophagus was also much narrowed

and deflected to the right. The enlargement extended mesially down to the left innominate vein.

Microscopically the thyroid showed no malignant characters, but the mediastinal glands in the neighbourhood showed commencing carcinomatous changes. Mr. de Santi referred to the difficulties such cases presented as regards tracheotomy, and stated that it was by no means uncommon to find these old-standing bronchoceles becoming malignant after many years, although orginally innocent.

Mr. Bowlby said the case illustrated exceedingly well the impossibility of removal of these tumours. It was a common experience, as far as malignancy was concerned, to find it commencing in a previously enlarged gland.

Dr. Herbert Tilley asked Mr. De Santi if he could say whether in this case the malignant disease started in the parathyroid structure, because in a lecture on goitre recently given by Mr. Horsley he had pointed out that such was often the case, a probability enhanced by the vascular and epithelial nature of this structure.

Mr. Bowlby said that was not his experience. He had seen malignant disease start in the substance of the thyroid itself, not in the parathyroid.

Sir Felix Semon had seen several cases start in the thyroid itself after the original goitre had remained unchanged for twenty years or more.

Case of Primary Epithelioma of the Right Tonsil with Extension to the Tongue and Cervical Glands.

Shown by Mr. de Santi. The man, æt. 37, had first noticed swelling in the right tonsil at Christmas, 1898, and had seen a doctor who said nothing was the matter with him. He was again seen later when he was told he had tonsillitis and given a gargle.

Now there was well-marked cachexia. A foul ulcer was seen in the right tonsil. The base of the tongue was involved and bound down, and there was inability to open the mouth wide. The right cervical glands were typically enlarged and hard. The case was inoperable and of very rapid growth.

Mr. Bowlby thought there could be no doubt as to the diagnosis, and that operative treatment was impracticable.

Swelling in Inter-arytænoid Region.

Shown by Dr. Furniss Potter. The patient was a man æt. 31, a meat salesman and voice user, who had suffered from hoarseness for about two months previously, and had had a cough with expectoration for an indefinite period—could not remember how long. On examination there was general hyperæmia of the larynx, the cords being thickened and slightly reddened. In the inter-arytænoid space was a pyramidal-shaped swelling, grey in colour as if covered with mucus.

According to patient's statement he had been a teetotaler for the last three years, but previously had indulged freely in alcohol. There was no history of syphilis. No loss of flesh. Examination of sputum for tubercle bacilli yielded a negative result. No definite abnormal physical signs in chest.

Sir Felix Semon thought care should be exercised in the use of the expression "growth in the inter-arytænoid fold," as it was the experience of practically everybody that benign growths in that region—he referred to real new formations—were amongst the greatest rarities of laryngological literature. Was Dr. Potter's case not much more likely to be an instance of inflammatory thickening, and in such circumstances was the use of the term "growth" justifiable?

Mr. Bowlby agreed with Sir Felix Semon, and asked if Dr. Potter would be willing to alter the title of the case. The term "growth" so definitely conveyed the idea of tumour formation as apart from inflammatory swelling that it was unfortunate to use it in a case like that before them.

Dr. Potter said he had had some doubt in describing the condition as a "growth." Perhaps "excrescence" or "swelling" would be more applicable.

Dr. William Hill thought the condition was not like an ordinary swelling or infiltration, if by that was meant something mound-shaped. It seemed to him rather of the shape of the typical tubercular *growth* in that position than of a mere tubercular swelling.

Case of Lupus of Nose and Pharynx.

Shown by Dr. Watson Williams. About two years ago patient, æt. 21, had a violent blow on the nose at football. The nose bled freely, and shortly afterwards became more or less persistently blocked on the left side. Crusts and discharge shortly after came from the left nostril, and after an interval of

about six months from the right nostril also. About this time a bicycle fell on his nose, producing the depression of the bridge so suggestive of syphilitic disease. There is no history of syphilis, nor any family history of tuberculous disease. Latterly the throat has been dry, and the voice husky.

The cartilaginous septum has completely disappeared, but I find no evidence of necrosis of the bone. The inferior turbinal and the remains of the septum appear to be superficially infiltrated with lupus.

The soft palate has been partly eaten away, and the remains of the uvula shows lupus nodules, with clean superficial ulceration in parts.

The posterior pharyngeal wall and the vocal processes in the larynx show lupus infiltration.

I was suspicious of a syphilitic infection, and put the patient on large doses of iodide of potassium, and also on mercury; but he developed iodism, while the local conditions only progressed. The local application of lactic acid 50 per cent. does not appear to control the disease. I have applied nitric acid to the pharynx and soft palate, and I propose to curette away as much of the infiltrated tissue as seems justifiable, and apply nitric acid.

Mr. Bowlby thought the suggestion, based on the statement of the patient, that the condition was the result of injury an exceedingly unlikely supposition. He believed it a case of syphilitic disease.

Dr. William Hill pointed out that the disease actually had extended to the larynx, there being an ulcer in the inter-arytænoid region, and there was also considerable destruction of bone in the nose, which was against the diagnosis of lupus.

Dr. StClair Thomson also believed it syphilitic. A blow would have to be a very straight one in the middle line of the nose to flatten it out as it had flattened this one. He did not think lupus, though it might destroy the nose very extensively, produced such retraction as this case showed; and the pharyngeal condition confirmed this view. Dr. Watson Williams had previously shown a case of true tuberculosis of the septum which had been treated with tuberculin, and he would suggest the idea of testing this case in that way before going in for any extensive treatment. If that procedure gave a negative reaction it might be advisable to treat the patient actively with inunctions of mercury before taking surgical measures.

A Case of Laryngeal Disease for Diagnosis.

Shown by Dr. W. H. Kelson. E. B—, a girl æt. 15, came complaining of loss of voice; duration two years; onset gradual.

Family history.—Parents alive; no history of consumption in family, but father has had bad throats, and sisters and brothers have had bad throats and eyes. Patient suffered from abscesses in the neck as a child. Three years ago suffered from interstitial keratitis, and as the eyes recovered deafness came on and loss of voice.

Condition on admission.—Patient is fairly well nourished. Auscultation of chest showed nothing abnormal; corneæ hazy. Central incisors rather pegged. Scars of old glandular disease in submaxillary regions.

Larynx.—Pinkish growths, having their origin apparently from the ventricles, obscure the view of the cord on both sides; portions of the growth have a warty appearance, other parts are smooth; the larynx is not at all tender on external manipulation.

Three months after admission: the patient has had two grains of Hydrarg. c̄ Creta in pill every day, and small portions of the growth have been removed with some improvement of the voice.

Present condition of the larynx: on the right side the growth has much receded and a slightly thickened cord is plainly visible. On the left side there is still much growth and only occasional glimpses of the cord can be obtained. The left side also does not move so freely as the right, and the arytænoid outline is not quite so sharply defined.

Sir Felix Semon thought it probably a case of syphilitic perichondritis with fixation of the crico-arytænoid joint and partial luxation of the arytænoid backwards, the processus vocalis springing more forward than was natural. With the other evidences to that effect, the explanation that it was a case of congenital syphilitic disease was a very likely one.

Mr. Spencer also thought it due to congenital syphilis.

Mr. Bowlby agreed with this opinion, and remarked that it was not a common experience to find the swelling clear up as it had done on the right side, leaving a perfectly free cord.

Case of Polypoid-looking Growth springing from the Right Supra-tonsillar Fossa.

Shown by Mr. Arthur Cheatle. A female patient æt. 21 had complained of discomfort in swallowing for a month.

On examination a smooth, pale growth, about one and a quarter inches in length, was seen projecting from the supra-tonsillar fossa and hanging over an enlarged tonsil but quite distinct from it. Sections of the growth will be shown at the next meeting.

A Case of Old Syphilitic Disease in the Nose of a Woman aged thirty-six.

Shown by Dr. Donelan. There was extensive destruction of all the intra-nasal structures. He desired the opinion of the Society as to whether a patch of thickened and inflamed skin on left side of nose was not an added tuberculous infection. There had been no change in this patch under anti-syphilitic treatment, though in the ten days it had been under observation the intra-nasal disease had been completely arrested.

Mr. Bowlby thought this case probably syphilitic. The term "lupus" might be employed indicating that it was a syphilitic lupus, but he did not think it at all like a tubercular affection.

Sir Felix Semon suggested that a tuberculin test might be applied.

Case of Miliary Tuberculosis of Fauces, &c.

Shown by Dr. Lambert Lack. Patient, a female æt. 26, is very anæmic and wasted. She has suffered from a cough for about two years; has been wasting for six months; and for the last six weeks has complained of sore throat.

On examination, the mucous membrane of the fauces and adjacent part of tongue and pharynx on the left side is reddened and slightly swollen. The surface is covered with minute, superficial, clearly-defined ulcers, with ashy grey, sloughy bases. At the periphery of the affected part the ulcers are distinct, and

vary in size from a pin's head to a millet seed. In the centre the ulcers are partly confluent.

The upper part of the larynx, the epiglottis, ary-epiglottic folds, and arytænoids are greatly swollen, and covered with superficial worm-eaten ulceration. The cords, as far as they can be seen, are normal. The voice is clear but weak. There is active phthisis at both apices with cavitation at the right.

At the first glance the condition of the fauces much resembles herpes.

Mr. BOWLBY said the condition was not at all a common one, and described the case of a young man, æt. 24, who came to him complaining of a tickling cough and some trouble in the back of the throat, but was supposed to be otherwise in tolerably good health. The affection was well marked, though not so far advanced as in Dr. Lack's case. It appeared to be a case of miliary tuberculosis, and heralded a very considerable extension of the disease, from which the patient died in three months time.

Dr. HERBERT TILLEY described an identical case, that of a man æt. 65, which was under his care last year, and in which there was laryngeal tubercle as well. The condition extended right on to the hard and soft palate, the base of the tongue also appearing superficially ulcerated. After a short while the patient died. Before coming to the hospital he had been practically starved because of the pain in swallowing. Nothing relieved the dysphagia so much as orthoform, a little of which blown on his pharynx and palate enabled him to swallow anything given him with perfect comfort for some twelve hours after the application.

Sir FELIX SEMON spoke of a case he was at present treating for laryngeal tuberculosis in which orthoform was proving of great use. The maximum effect of the application, according to the patient, was experienced in an hour; it lasted for about three hours. The susceptibility of different patients to its influence seemed to vary. Orthoform was not poisonous, and in that respect more advantageous than cocaine; it could in an emergency be left in the hands of untrained people with impunity. Its effect was also more continuous. For the application to be effective there must, in his hitherto limited experience, be a breach of surface. In cases of simple infiltration he had so far found it had no effect whatever. It was a useful application in cases where only palliative measures could be adopted. It had been lately recommended in Germany as an excellent thing in vasomotor coryza; but in two cases in which he had tried it, it had been absolutely ineffective.

Dr. MACGEAGH had also obtained good results from the use of orthoform in tubercular disease of the larynx, the effect lasting for two hours.

Dr. STCLAIR THOMSON said he had tried orthoform to relieve the dysphagia after removal of the tonsils, but with no success. The pain in that case seemed to be more traumatic.

Dr. LACK had found orthoform extremely useful in preventing the neuralgia which occasionally followed the dressing of wounds, as in the case of the mastoid or maxillary antrum when the cavity was packed.

CASE OF LYMPHO-SARCOMA (?) OF TONSILS.

Shown by Dr. LAMBERT LACK. The patient, a man æt. 46, has noticed a small swelling on the left side of the neck for six years. The swelling has been increasing ever since, but during the last twelve months it has grown more rapidly. Patient has always been subject to attacks of acute tonsillitis.

Present condition.—Both tonsils are enlarged, the left being very large, projecting beyond the mid-line, and very broad. It is firm, not densely hard, and is not ulcerated. There is a large, hard mass of glands in the anterior triangle on the left side, firmly fixed to the angle of the jaw and the surrounding muscles &c. A few small glands, also fixed, in a similar position on the right side. The left side of the tongue is paralysed and completely atrophied. The larynx is pushed over to the right. The pupils are unequal, the right being the larger. The man is in good health, has no pain, can swallow easily, and complains only of the swelling in the neck.

Mr. BOWLBY thought it a case of malignant disease, more probably lymphosarcoma than carcinoma, and that it was inoperable. The glands seemed to be more movable, rounded, and circumscribed, less hard, and causing less infiltration of the tissues and contraction around than in carcinoma. After a lymphomatous mass had existed for years it often took on more rapid growth, and in some cases was, in others was not, amenable to arsenic.

Mr. SPENCER said that the glands seemed hard and the infiltration of the hypoglossal nerve suggested that a good deal of the enlargement of the tonsil was secondary or inflammatory, and that there must be a deep-seated ulcer behind the tonsil which had extended to the glands. Unless it be the very malignant, infiltrating, and bleeding forms, lymphosarcoma caused a large tumour in the throat, and had been easily removed. It also generally occurred in women. From the infiltration of the hypoglossal nerve he should have thought the disease carcinoma.

CASE OF CYST OF THYRO-HYOID BURSA.

Shown by Dr. FITZGERALD POWELL. Patient, a man æt. 40, states that seven or eight months ago he caught cold, after which he

felt a small swelling on the outside of his throat which, after a time, completely disappeared, but on again catching cold the swelling returned and has gradually got larger ever since.

There is no tenderness on pressure and no pain and the tumour gives rise to no inconvenience.

On presenting himself at the hospital, a round, movable, fluctuating tumour, the size of a pigeon's egg, was felt to the left of the thyroid cartilage. It moved up and down on swallowing, and apparently was attached above to the hyoid bone.

I considered this to be a cyst of the thyro-hyoid bursa.

Mr. Bowlby thought that, on account of its lateral position and its feel, it might turn out to be a cyst of the pyramid of the thyroid gland on the left side. Bursal cysts he believed to be more in the middle line. In the case of bursal cysts passing up behind the hyoid, it was better to leave them alone unless they caused much trouble. He was inclined to advise removal in the case of this laterally placed cyst, although it did not at present give much inconvenience.

Dr. Pegler asked if members had met with successful results of operations in such cases.

Mr. Bowlby said he had successfully operated on a patient who had been three times previously operated on for a sinus left after removal of a bursal cyst. He had seen other cases cured after operation, but they were certainly very troublesome.

Dr. Fitzgerald Powell asked whether tapping or injecting should be employed when these cases were not operated on.

Mr. Bowlby thought it would not be wise. The cyst should either be left alone or simply removed.

Case of Laryngeal Ulceration.

Shown by Dr. Fitzgerald Powell. Patient, a man æt. 23, complains that in December of 1898 he caught a severe cold in his throat, accompanied by cough and loss of voice, from which he had, however, quite recovered under treatment by his medical attendant.

In March, 1899, the loss of voice again occurred, and has continued to get worse up to the present. He says he has no pain or expectoration and no difficulty in swallowing. He has not lost weight or flesh, but, on the contrary, has gained both.

Laryngoscopic examination reveals considerable swelling and redness of the whole of the larynx, particularly the ventricular bands, cords, and inter-arytænoid region, the swelling extending

on to the under surface of the arytænoids themselves. The vocal cords are much thickened and irregular, and about the centre of the right cord is a dirty-looking greyish patch of ulceration and another at the posterior end of the left cord. The arytænoids are red in colour and are not œdematous.

There is no history or evidence of syphilis, and careful examination fails to reveal any tubercular disease in lungs or elsewhere. His voice has slightly improved under treatment by iodide of potassium and soothing inhalations.

Dr. HERBERT TILLEY thought the case was a tubercular one, and suggested that the patient's evening temperature should be taken for a fortnight. It was possibly true there were no physical signs in the lungs, but in cases of tubercular disease of the larynx where physical signs in the lungs had been slight the evening temperature often gave a good clue as to the nature of the disease.

CASE OF PERVERSE ACTION OF VOCAL CORDS.

Shown by Dr. HERBERT TILLEY. Patient is a female æt. 23, of markedly neurotic temperament, who sought hospital relief for loss of voice of five weeks' duration.

Inspiration was accompanied by laryngeal stridor, and every few seconds the patient made a curious barking noise which could be scarcely called a cough. Examination showed that the vocal cords were adducted during inspiration. The passage of a laryngeal brush through the glottis practically cured the symptoms.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

50TH ORDINARY MEETING, *May 5th*, 1899.

F. DE HAVILLAND HALL, M.D., President, in the Chair.

WILLIAM HILL, M.D., }
LAMBERT LACK, M.D., } Secretaries.

Present—33 members and 9 visitors.

The minutes of the previous meeting were read and confirmed.

The following gentleman was nominated for election at the next meeting:

Charles Heath, F.R.C.S., 3, Cavendish Place.

DISCUSSION ON ASTHMA IN ITS RELATION TO DISEASES OF THE UPPER AIR-PASSAGES.

The PRESIDENT in a few introductory remarks said that it had been decided to devote this meeting to a discussion upon "Asthma in its relation to Diseases of the Upper Air-passages." This subject in many respects was a purely medical one, and illustrated the importance of the laryngologist being not only a surgeon but an able physician. He was glad to announce that Dr. Percy Kidd had consented to open the discussion with the medical aspect of the case, and that Dr. P. McBride would follow, and treat the subject from the point of view of those who practised more especially in the diseases of the upper respiratory tract.

Dr. PERCY KIDD said: In accepting the invitation of the Council to

assist in opening the present discussion, I felt more than the traditional hesitation professed on such occasions from the conviction that there must be many members of the Society who have had a larger experience of the subject in certain of its aspects. But hearing that my task was to be shared with Dr. McBride I took courage, for I had the assurance that any deficiency on my part would be more than made good in his address. In order to promote discussion and not to occupy too much time I shall endeavour to make my remarks as short as possible, avoiding any attempt to discuss the literature of the question, and dealing mainly with matters of which I have had personal experience. According to the generally prevailing view, asthma is essentially a neurosis, in which the respiratory system is predominantly engaged, though reflex relations with other organs are often manifested. In speaking of asthma I refer only to what is commonly described as bronchial asthma, no mention being made of cardiac or renal asthma. It is well known that nasal symptoms, sneezing, hypersecretion, and obstruction of the nares, are not uncommonly met with in connection with asthma, and great attention has been devoted to this relation since Voltolini succeeded in curing a case of asthma by removing nasal polypi. The pathology of the asthmatic seizure is still somewhat uncertain, the theories most in favour ascribing the dyspnœa either to spasm of the bronchial muscles, or to vasomotor dilatation of the blood-vessels of the bronchi. A considerable advance in our knowledge was undoubtedly made when the close relations of bronchial and hay asthma became recognised, for a strong side-light was thereby thrown on the pathology of the asthmatic paroxysm. In view of the phenomena of hay fever one can hardly doubt that vascular dilatation plays a very important part in the production of asthma, whatever the influence of spasm may be, and the tenacious pearly sputum of asthma with its peculiar spiral threads is quite as easily explained according to this view as by the assumption of a special form of bronchiolitis.

To return to the subject of the relation of nasal disease to asthma. It appears to me that the frequency of this association has been much exaggerated, particularly by Bosworth, who says, to quote his own words, that "a large majority, if not all cases of asthma are dependent upon some obstructive lesion in the nasal cavity." It is assumed by this writer and others that nasal symptoms in asthma are invariably the result of some definite local lesion, and that asthma is a reflex result of the morbid condition of the nose. It cannot be denied that nasal symptoms may precede, accompany, or alternate with attacks of asthma, but the evidence forthcoming in support of the view that the two groups of phenomena necessarily stand in the relation of cause and effect is not altogether convincing. It cannot be said that there is anything characteristic in the nasal changes found in asthmatic subjects polypi, periodical swelling of the mucous membrane of the inferior turbinal and other parts, hypertrophic rhinitis, œdematous swelling over the cartilaginous septum, and various obstructive deformities, such as spurs and deviations of the septum. These conditions are common enough, and yet it is quite the exception to find them associated with asthma. According to my experience, the state

of the nasal cavity in asthmatic persons is generally substantially sound. The strongest proof of the influence of nasal disease upon asthma consists in the relief to the paroxysms of dyspnœa that sometimes follows surgical treatment of the nose.

In some cases (I should say, a very few) the amelioration is so marked as to suggest that the asthma was a reflex result of the nasal disorder. But in most instances any improvement that ensues is temporary and incomplete. If we remember what marked mitigation of the asthmatic seizures may follow an unimportant modification of drugs, a change of residence, or some powerful emotion, we shall be loth to credit any slight improvement to surgical operations on the nose. One of the worst cases of asthma I have seen obtained more relief from a course of compressed air-baths than from any other measure, including hypodermic injections of morphia. It is hard to resist the suspicion that the success of the compressed air-bath was largely due to psychical influences, and some of the apparent triumphs of nasal surgery are perhaps susceptible of a similar explanation.

To sum up my own experience. I have seen two or three cases of asthma associated with polypi, and in two of these removal of polypi was followed by manifest relief to the asthmatic condition. Unfortunately the patients were lost sight of, and their subsequent history is unknown to me. A moderate degree of swelling of the inferior turbinal, more particularly of its posterior extremity, was met with in a few asthmatic subjects. But in only one instance was there any noteworthy obstruction to nasal respiration, and except in the case of this patient, I have not felt justified in proposing cauterisation or removal of the swollen tissues. The patient referred to remains under observation and has been recommended to undergo appropriate local treatment, the uncertainty of the result *quâ* asthma having been explained to him. Periodical swelling of the inferior turbinal may have existed in some cases from the history of passing nasal obstruction given by the patients, but I have had no opportunity of verifying this surmise. I do not remember to have seen any instance of gelatinous swelling of the anterior septal region, or of any marked development of spurs, in this connection. No cases of asthma with adenoid vegetations in the naso-pharynx have come under my observation. Of localised areas of hyperæsthesia in the nasal cavity I have no experience to offer. It may seem that this account reads very like a confession of inexperience. But it must be borne in mind that the cases to which I refer presented themselves on account of asthma primarily, whereas asthmatics that apply for relief to specialists in the domain of laryngology and rhinology, are likely to comprise an unduly large proportion of cases of pronounced nasal disease. The clinical history of cases in which sneezing and other symptoms of hay fever alternate with, or are succeeded by, spasmodic dyspnœa may be regarded as supporting the reflex nasal origin of asthma; and the same view may be taken of asthma induced by the smell of the cat, horse, dog, powdered ipecacuanha, violets, roses, &c. But, as Semon and Watson Williams point out, where the attacks ensue on the inhalation of irritant particles like pollen and ipecacuanha, it is not impossible that asthma may be the result of a bronchial

rather than a nasal reflex, some of the fine powder reaching the lower air-passages as well as the nose. It is generally admitted that for the production of hay fever at least two factors are required, viz. an external irritant and a morbidly sensitive nervous system. Some writers consider that a further element, a pathological condition of the nasal mucous membrane, is also necessarily present, a statement which I cannot accept as correct for all cases. I am inclined to believe that too much is now-a-days expected of the nose, and the result is that the happy individuals that would be certified as possessing an ideally healthy nose are comparatively few. If rhinological examination is conducted according to this counsel of perfection, we need not be surprised that most if not all patients with nasal symptoms are found wanting.

The following conclusions appear to be justified. In some cases asthma is relieved by the removal of polypi, though the explanation of this effect is still very obscure. Hay asthma may sometimes be benefited by treatment of morbid conditions of the nose and naso-pharynx, an experience of which, at present, I can claim no personal knowledge. The prospects of improvement in such circumstances as in the case of polypi seem to be very uncertain, but in the presence of definite nasal stenosis local treatment is not only warranted but advisable. In the ordinary form of asthma uncomplicated by hay fever or polypi, nasal symptoms are not uncommon, but the nose is generally healthy and requires no local treatment, though a spray of cocaine is said to give relief in some cases. Here the nasal symptoms may be regarded as merely part of a general vaso-motor neurosis of the respiratory tract. The history of some instances of hay asthma, in which spasmodic attacks persist in the winter although the nasal symptoms are then in abeyance, shows how important is the neurosal element, quite apart from the existence of peripheral irritation of the nares.

Dr. McBride said: In addressing an audience of specialists it would be out of place—it would almost be an impertinence—to consider the relation of asthma to the upper air-passages from an historical point of view. The names of Voltolini, Hack, B. Fränkel, and many others will at once occur to you all as pioneers whose teachings have been of great value in calling attention to a connection which is admitted by all thoughtful physicians and specialists of to-day. Again, it would be equally out of place to ask you to follow me through the immense mass of literature which relates to reflex neuroses, of which asthma is probably the most important. This literature is in its main facts, no doubt, familiar to all here. As you are aware, it is abnormal conditions of the nose which have been most generally found to cause asthma, and it has seemed to me, therefore, best to begin my remarks with the heading—

Nasal Asthma.

The most generally known form is undoubtedly the variety which occurs in the course of hay fever and allied conditions. You are all familiar with the chain of events in these cases—the symptoms of coryza induced by the pollen of grasses and flowers, dust, and the like,

or more rarely by emanations from animals, chemicals, and a variety of other causes, followed in certain persons by asthma which differs in no respect from the affection as commonly described in our medical text-books. In this chain of events we have an illustration of nasal asthma in its most familiar form, and it is generally admitted that hay fever requires for its development a neurasthenic, or at least a neurotic condition which acts as a predisposing cause. Of course you are all aware that in a proportion of cases we find more or less marked abnormalities in the nasal passages, but I am quite sure that in a very large number of instances these parts are, excepting during the attacks, for all practical purposes normal.

I take it that the course of events is as follows: the specific irritant touches the mucous membrane, which, in order that the other phenomena may result, must be hyperæsthetic; erectile swelling then occurs followed by hypersecretion. In certain persons a reflex asthma is set up by the nasal irritation. It is well known that hay fever is to some extent dependent upon race, thus Anglo-Saxons are more prone to be affected than persons of other nationalities. It seems also to be influenced very materially by social position, for I presume that most of us have observed it either chiefly or entirely among the better or, shall I say, wealthier classes. Speaking for myself I have seen numerous cases, but with one or two exceptions they have always occurred in private patients.

A less common but still a relatively common form of nasal asthma is that which seems to depend upon the presence of nasal polypi. In these cases the nostrils are usually not completely occluded, so that the presence of the growths may escape observation unless attention be directed to this point. I have now seen a considerable number of people who suffered from asthma, and in whom nasal polypi existed. Where this combination occurs I consider that we may very reasonably expect to benefit the former by removal of the latter. It is somewhat difficult to explain why small polypi should be more liable to cause asthma than large growths, but probably the former being more mobile are for this reason more likely to irritate the mucous membrane.

In certain cases of hypertrophic catarrh and deviations, or outgrowths from the septum, we also meet with asthma which may be benefited by local treatment. Sometimes the pathological condition is obvious and so marked as to interfere with nasal respiration, and thus give rise to local discomfort. In such cases there can be no great difficulty in determining upon the proper line of treatment. In other instances, however, deviations from the normal are slight—so slight that perhaps we should not be justified in calling them pathological. Gentlemen, I know I am treading on thin ice when I say that we have as yet no satisfactory definition of a normal nose. We know very well what the anatomically correct organ should look like—the nasal septum should be straight and have no outgrowth, the middle and inferior turbinated bodies should be of a certain size, shape, and colour. This is the ideal, but we rarely find it, just as it is uncommon to find perfection elsewhere in this world. I have introduced this matter in order to lead up to the fact that we are often called upon to

make rhinoscopic examinations of asthmatics, and frequently find nothing, which if discovered in another person we should be justified in stigmatising as pathological. I think I may say without offence that rhinologists all over the world are divided into two classes. One holds that it is most desirable for a man's nose to be symmetrical, not only externally, which we all admit, but also internally. Gentlemen of this persuasion make it their business to straighten every septum which is not mathematically straight, to remove any excrescences which they find disagreeable to the examining eye, and finally to reduce the turbinated bodies to such size as seems proper to them. Those who belong to the opposite camp tend to limit treatment to cases in which the condition of the nose is such as to produce nasal symptoms appreciable as nasal by the patient. I fancy that most of us here hold with the second class, and I need hardly say that my own views are decidedly conservative with regard to nasal surgery. At the same time if these conservative views in their entirety be brought to bear upon nasal asthma they may prove misleading, and, moreover, if your patient falls into the hands of a nasal specialist who believes no nose normal, he may effect a cure where you have failed.

I do not wish to say that I have met with nasal asthma in an absolutely normal nose, but it appears to me that in some asthmatics nasal treatment is permissible and even desirable, where the conditions are such that on other grounds operative measures would certainly not be indicated. Thus, if the bronchial attack be preceded by sneezing and nasal hypersecretion, the application of the electric cautery may be beneficial, just as it is in some cases of hay fever, even if at the time of application the parts are fairly normal. I take it that in some of these cases this treatment is beneficial by destroying nerve-endings through which reflex vasomotor changes are produced, while in others good results are obtained by the formation of cicatrices, which bind down the erectile tissue and thus prevent swelling. I do not think, however, that in all cases the paroxysm is preceded by nasal symptoms, even where nasal treatment may do good. I have, however, found that in a considerable proportion of asthmatics there can be detected on the nasal mucosa spots which, when touched with a probe, produce cough. My experience has been that in almost every patient who shows this phenomenon, the application of the electric cautery to these sensitive areas will produce marked amelioration, amounting, in some instances, to a practical cure. These cough spots may be met with in any part of the mucous membrane, but are most commonly situated on the inferior turbinated body, while occasionally the reflex area may be encountered while passing a probe between a projection from the septum and the outer wall. I have said that I consider the presence of this reflex cough as an indication in favour of intra-nasal treatment, but I have not found that when it is absent such treatment is always useless, although in the one case we are entitled to express a conviction in favour of the probability of benefit, while in the other operative measures must be looked upon as more or less experimental so far as the asthma is concerned. I cannot help thinking that the clinical value of this symptom has been overlooked, although I have repeatedly

called attention to it for many years. In this connection a very interesting question confronts us, may it not be possible to benefit asthma in certain cases by applying the cautery to a normal nostril? The fact that we speak of a nasal reflex asthma implies that we admit something like the following chain of events: a stimulus travels from the periphery to a centre, and there sets up molecular changes, which result in a paroxysm of asthma. Observe we admit that an irritant applied to the nasal mucosa may effect molecular changes in a centre which is responsible for asthma. It almost follows as a carollary that we can influence this centre from the nose, and I very much question whether many asthmatics—even those with normal noses—might not be benefited by the use of the electric cautery, not as a destroyer of tissue, but as a counter-irritant.

It may, perhaps, not be amiss to glance for a moment at the prognosis of nasal asthma. I do not think it is ever safe to promise the patient a cure, because every thinking rhinologist will admit that the nose is rarely, if ever, the only cause of asthma. In cases of polypi, however, we can usually do much good by removal of the growths, and when we have the introduction of a probe into the nostrils followed by cough, the probability of benefit is much increased. In ordinary hypertrophic catarrh, and in the case of spines or deviations, the last-named symptom becomes of even more significance.

Asthma caused by other Parts of the Upper Respiratory Tract.

While nasal asthma is comparatively common, it is in my experience rare to have this neurosis produced by other parts of the upper respiratory tract. I am aware that cures have been reported after removal of enlarged tonsils and after destroying granulations upon the posterior pharyngeal wall, but I do not remember to have met with such cases myself. On one occasion only have I found asthma apparently cured by removing adenoids from a young boy. I have thought it well, thus, at the risk of appearing egotistical, to confine my remarks to an expression of personal experience and views. To discuss the subject by any other method would have occupied much time without any commensurate advantage.

In conclusion, I would venture once more to express my conviction that while the upper air-passages may be the exciting causes of asthma, its occurrence depends upon some individual predisposition. We can therefore hardly speak of cures by local treatment of the nose and throat without modifying the expression, and we must not forget to use such general remedies and modifications of regimen as have been found useful by physicians generally.

Dr. J. C. Thorowgood expressed his thanks to the Society for allowing him to be present as a visitor, and to be able to listen to such interesting papers, whose wisdom he admired. He thought with the last speaker that it was quite right not to promise the patient cure from asthma, and he remembered a case in which he had been consulted where, by following this plan, he had been able to prevent troublesome consequences. Speaking from his own experience, he

could not agree with Dr. McBride that asthma was not very often associated with adenoid growths; he had come across cases where the removal of adenoid growths had much mitigated the attacks of asthma, and in one case the patient had been almost free from asthma owing to the removal of these growths. He was quite convinced that there are certain areas in the air-passages which, when touched, give rise to paroxysms of asthma—this had occurred on the removal of polypi; one had to be particularly careful not to excite these centres in highly neurotic patients. In alluding to the effect of asthma on the circulation, he mentioned a case in which, other remedies having failed, chloral gave marked relief. Being a dilator of the vessels, theoretically chloral ought to answer if, as he believed, the asthma was due not to vaso-motor dilatation so much as to violent spasmodic contraction of the vessels.

Mr. WAGGETT believed that it was very seldom that a causal relationship between true spasmodic asthma and nasal disease could be established on a strictly logical basis. Although he had many opportunities of meeting with these cases he could remember but one instance in which the nasal origin of the trouble was proved with any real certainty. The case in question was that of a man of forty, who complained of distressing attacks of asthmatic character which had persisted for twelve years in spite of medical treatment. The attacks occurred at all times of the day but more particularly after lunch, and lasted about an hour or so. To quote the patient's own report: "They commenced with tightness amounting to severe pressure across the bridge of the nose; suffocating feeling about the throat, and apparent inward pressure from the ears. There was distinct tightness of the chest—very little wheeze—but difficult breathing with much effort to clear the throat; generally, too, there was dryness of the throat, and, on the whole, the feeling was that one would fall down." On examination a very large septal spur was found pressing tightly against the right inferior turbinate in its middle part, the nose, in other respects, being unusually patent. The spur was removed and the attacks immediately ceased. Eight months later the patient returned, stating that the attacks gradually recommenced about two months after the operation and were again very distressing. A large bony bridge was discovered stretching between the inferior turbinate and the site of operation. This was removed and the attacks at once ceased. Five weeks ago the patient reappeared, stating that the attacks recommenced about four months after his previous visit. A narrow bony bridge was again found in the former situation. This was removed and the patient reported himself as being, for a third time, relieved of his attacks. The general conditions of the patient as to occupation and place of residence had remained unaltered throughout the course of the case. On no occasion could an attack be induced by experimental irritation of the nasal fossæ. The interest of the case, which was one of diffuse neurosis embracing the symptoms of true spasmodic asthma, lay in the sequence of events, the cardinal point being the disappearance of the special symptoms on three occasions as a sequel to three almost identical intra-nasal operations. Even in this case a causal relationship between the neurosis and the

nasal lesion could not be absolutely established, as no evidence was forthcoming that the reappearance of symptoms coincided in point of time with the bridge formation. The speaker was compelled to believe that true nasal asthma was a rare disease, and inasmuch as it was often spoken of as an everyday occurrence, he thought it would be valuable if members would take this opportunity of furnishing statistical data.

Dr. MacIntyre (Glasgow) said, while he could fully understand the desire to obtain exact statistics we had to remember one difficulty. The patients who came back to us were very often those in whom the treatment had been unsuccessful, judged from the standpoint of being cured, whilst those that got relief were not so easily traced. Judged from every standpoint, however, he thought that from his own experience he could recall a few cases of which it would be justifiable to use the term cured. These were a very small minority, and, like others, his experience had been such as to induce him to speak of relief rather than cure where success was claimed for treatment. He thanked both gentlemen for the manner in which they had introduced the subject, knowing the difficulties in opening such a debate. On the one hand, while there might be over-enthusiasm and too great a tendency to surgical procedure, nevertheless the openers of such a discussion had a certain responsibility in presenting their views, because it was possible to throw such an amount of doubt upon the matter as to damp the enthusiasm and ardour of those who are inclined to investigate this difficult and as yet experimental branch of surgery. Further, it was exceedingly difficult before beginning the treatment of a case to give an exact prognosis, notwithstanding the fact that in a certain number of cases, as a matter of experience which could scarcely be conveyed in language, the surgeon felt more hopeful than in others. Asthma might be induced from an irritation of the nasal membrane, but other causes might exist in the same patient. He gave instances of the difficulty of arriving at a prognosis by quoting two cases in which patients had been sent for surgical treatment in the nostrils, and in one of which it was ultimately found that the irritation was due to a sarcoma at the base of the skull, and a second was ultimately traced to a neoplasm in the mediastinum. There was one point which had not been spoken of as yet, and that was the information which might be got from a study of the action of the diaphragm, which was not always the same in cases of asthma, but which could now be observed. At present he was engaged in a series of investigations not yet published bearing upon this, and it was not at all impossible that, in some cases at least, light would be thrown upon the subject by the differential diagnosis which might be got by means of the X rays.

Dr. Herbert Tilley said that his experience was very similar to Mr. Waggett's, and he thought that only a minority of cases of asthma would be found amenable to surgical treatment of the nose. Cases of inherited asthma had received no benefit from intra-nasal treatment at his hands, and his experience in these cases was, perhaps, larger than is usual, because both in his own and his wife's family asthma was an unfortunate constitutional legacy. He had recently operated on a young sister-in-law who had commenced her asthmatic

career—the paroxysms coming on at night or even in the daytime after violent exercise, *e. g.* cycling uphill or horse-riding. He removed a post-nasal growth, and later on the anterior ends of both inferior turbinates because they were producing marked nasal obstruction, and the patient was always suffering from sneezing fits and severe colds. Here was a case which seemed to be an excellent test case for intra-nasal treatment. It was now nearly two months since the treatment was carried out, the patient expresses herself as delighted with the comfort of free nasal respiration, but the asthma attacks are "about the same, if anything a little better, but the medicine (Potassium Iodide, stramonium and arsenic) keeps the attacks off as long as it is taken." He thought that such would be the experience of others in inherited cases, as also in gouty asthma; at the same time he would not deny that occasionally cases might be immensely relieved by intra-nasal treatment, on the same principle that epileptic attacks had been completely cured by removal of nasal polypi, but such cases would be a minority. The speaker described his own personal experience of asthma, which was typical of "place asthma," *i. e.* in certain parts of England he was almost sure to get an attack about 2 o'clock in the morning, the attacks lasting some two hours and then completely passing off. In London he was always free, and if returning from the country with an attack upon him, nothing produced such splendid relief as a journey by the underground railway. Recently going down the Channel he had had two severe attacks whilst in his cabin below deck, the attacks passing off immediately he went on deck. He considered his case was probably gouty asthma, as his father was a martyr to the latter disease. His asthma attacks were not preceded by any nasal irritation or catarrh, and in spite of the suggestion of his friends he scarcely thought it worth while at present to undergo nasal treatment. With reference to destroying the sensitive areas in the nasal mucous membrane referred to by Dr. McBride, he had almost discarded the galvano-cautery for this purpose, because trichloracetic or even glacial acetic acid seemed to possess more penetrative and permanent properties. The only cases in which he could consider he had *cured* asthma by surgical treatment were those in children where the disease was associated with large tonsils, post-nasal growths, and accompanying bronchial and nasal catarrh with much secretion—these were very favourable cases, but he could not say the same for cases of genuine spasmodic asthma in the adult.

In reply to Dr. MacIntyre Dr. Herbert Tilley said that he thought it was scarcely scientific in a test case to give iodide of potassium whilst surgically treating the nose, because they all knew what relief that drug alone would give.

Dr. Scanes Spicer considered that Dr. McBride had very judicially reviewed the question under discussion. On the present occasion he would desire to remark on two points mentioned in Dr. McBride's opening, *i. e.* (1) the word "experiment" as applied to a surgical measure; (2) the term "a normal nose." As to the word "experiment," the public is apt to be misled by ambiguous terms. The word experiment is ambiguous. Most persons regard it, used surgically, as equivalent to a vivisection or laboratory research, and as implying

something rash and risky—a kind of "kill or cure" procedure. This idea is widespread. The consequence is that a critic who describes a suggested procedure as "an experiment" tends to excite a prejudice against it and to prevent dispassionate consideration, whereas all the critic is justified in predicating is, that the procedure is not certain to "cure radically" every case—which, indeed, is true of all therapeutic measures. Unless, indeed, he desires to be understood as meaning by the word a procedure of which the result is sure and unvarying, as in a chemical or physical experiment. Since, then, the idea that any given surgical procedure is not an infallible cure for every case can be expressed in unambiguous English terms, and those not calculated to excite prejudice, the speaker thought that the use of the word experiment in clinical therapeutics was inappropriate and unwise, and should be discouraged. He regretted that it had, in this connection, crept into Dr. McBride's excellent book. With reference to "a normal nose" no definition had yet been agreed upon. Could any nose be called normal in which the patient was conscious of suffering or discomfort? Thus, although no spur, polypus, or other gross lesion might be found on examination, the nose may regularly be obstructed at night and cause insomnia, restlessness, &c., as a consequence of the nasal discomfort; that is to say, a nose which may appear normal during the day when patient is erect, becomes insufficient at night when he is horizontal. And here a protest should be entered against a widespread notion that spurs should be operated on *quâ* spurs and as deviations from a theoretical symmetrical ideal. Such a procedure should be strongly discountenanced. The correct indications for attacking a spur are: (1) that it acts as an impediment to the due physiological intake of air, with consequent alteration of normal air tension on the nasal mucosa and in the pneumatic accessory spaces; (2) that it is in abnormal contact with other intra-nasal structures, either permanently, or periodically on mucosa turgescence, and leads to irritative and reflex disturbances. Hence, a large spur may often be ignored if in a cavity otherwise roomy, whereas a small one in other relations and situations demands attention. It is this insufficiency of passage and presence of abnormal contacts which form the true criteria of interference. Hence, a nose which presents no obvious pathological changes, and may so be regarded in one sense as normal, is abnormal, if from arrested evolution its channels are inadequate to admit the air demanded by the organism of which it is a part. His own experience had convinced him of the positive and great benefits derived in many cases of "asthma" from thorough nasal treatment, which was not to be expressed in terms of polypi and galvano-cautery. A few patients were prepared to maintain they were cured, while the majority obtained great relief; but the speaker's cases were not, with very few exceptions, drawn from the class of fossil asthmatics which would gravitate to the chest physicians, and were in nearly all instances less confirmed cases of spasmodic dyspnœa, in which other troubles—usually nasal—were as prominent as the asthmatic condition.

Dr. P. Watson Williams (Bristol) reported one case in which intra-nasal treatment, in conjunction with general treatment, had

apparently resulted in practically a complete cure, as for three years the patient had been free from asthma. The patient came to him five years ago with constant asthma, which had persisted more or less for eighteen years. She was having at least two paroxysms every twenty-four hours, as they came on both day and night. The mucous membrane of the nose was very hyperæsthetic, but there were no particular spots of special irritability, nor did sneezing, cough, or asthma occur on probing. The mucosa over the septum and turbinals was œdematous, and to such a degree overlaid the middle turbinals as to be polypoid. The polypi were snared and the bases and surrounding sodden area cauterised. Violent attacks of paroxysmal sneezing alternated with the attacks of asthma, and the patient experienced marked temporary relief from the use of a cocaine spray. There was therefore good reason to believe that the intra-nasal irritation had a close connection with the asthma in this case.

We do not know for certain what is the actual condition of the bronchi in asthma, but it seemed to him that there is sufficient ground for believing that the paroxysm is due to excessive contraction of the bronchial muscular coat and of the bronchial arteries. He was unable to accept the view that it is due to vascular dilatation. Radcliffe Hall, cited by Walshe, considered the use of the bronchial muscular coat was by its "tonus" to counteract the effect of coughing. But is it not possible that it, like the alæ nasi and vocal cords, may rhythmically dilate and contract with deep inspiration and expiration, and that in asthma the normal "tonus" is heightened, and while imperfect *dilatation* occurs during inspiration, the *contraction* phase is excessive during expiration? There is expiratory, not inspiratory dyspnœa; consequently the air in asthma, and in bronchitis too, distends the chest. It is difficult otherwise to understand why dyspnœa is expiratory and the chest gets distended. If there be such a closely associated physiological action between the movements of the upper and lower respiratory tracts, we can readily comprehend how in some cases there seems such close interdependence in their *morbid* relationship.

When we come to discuss this relationship between intra-nasal disease and asthma, we are confronted at the outset by the difficulty in deciding what constitutes a morbid condition of the nasal passages. He had no manner of doubt that in a very large percentage of asthmatic patients the nasal passages present conditions which cannot be regarded as ideal, and when we have excluded all septal deflections and spurs, turbinal hypertrophies, polypi, general hyperæmias, &c., there will be only very few cases left to participate in the other very numerous intra-nasal defects which civilised humanity is heir to. Moreover, we have ample testimony that *removal* of these defects—especially, in my experience, removal of polypi and cauterisation of markedly hypertrophic turbinal bodies—will be followed in a very large proportion of cases by more or less prolonged amelioration, or even cessation, of asthmatic attacks. But it was very difficult to decide how far the nasal affection is the cause of the asthma, even in those cases in which intra-nasal treatment has proved successful in relieving the asthma.

When one bears in mind the association of asthma with various

neuroses and with gout and renal disease, the very *frequency* with which nasal disease is associated with asthma should make one suspicious that there was something more than simple cause and effect in their relationship. Dr. Watson Williams thought that most frequently the intra-nasal affections, such as hypertrophic rhinitis, water-logged mucous membranes, and perhaps even sometimes œdematous polypi (he took but little notice of minor septal deformities), are the *consequence* and not the cause of the asthma, and sometimes there may be no evidence whatever of their existence until after the asthmatic paroxysms have recurred for years. Yet such experience as he had had made him very unwilling to leave untreated any obvious intra-nasal defects in an asthmatic patient which could really be a cause of irritation or an embarrassment to nasal respiration; since the removal of any contributory factors towards the occurrence of the paroxysms, although they might not be the essential cause, will often materially aid our efforts in other directions to combat the disease, whilst occasionally the happy results that follow the intra-nasal treatment seem conclusive proof that therein lay the essential cause of the malady.

Dr. THEODORE WILLIAMS could recall one case of asthma cured by the removal of nasal polypi, but from the discussion which had taken place he gathered that the Society was not in favour of operating on the nasal cavities in order to cure asthmatic attacks, a conclusion of some comfort to himself, as he doubted whether he had recommended operations as often as he might have done. For the medicinal treatment of genuine spasmodic bronchial asthma generally, he found iodide of potassium in eight to ten grain doses three times a day combined with stramonium, henbane, or belladonna of great advantage, and if these failed, compressed air baths, such as were used at the Brompton Hospital, gave great relief.

Dr. W. PERMEWAN thought the distinction between "great relief" and "cure" was an extremely narrow one; cure was a large word, and not very properly used in a question of this kind. In the majority of cases relief was very great, and unmistakably the result of treatment was to give relief.

Sir FELIX SEMON: How long lasting?

Dr. PERMEWAN: Until necessity arose for further intra-nasal treatment. Of the variety of nasal diseases polypi were by far the most important, and he agreed with those who deprecated the indiscriminate use of the cautery. He thought that a normal nose, considered from a surgical point of view, was one which offered no point of attack to the surgeon. He believed that asthma was the result of a nasal condition, and that he was perfectly justified in healing the nose though he could find objectively nothing to attack. He emphasised the importance of respiration through the nose; if a patient's nose was blocked up with polypi, and he is unable to breathe through it; that is the factor which starts asthmatic paroxysms, and not a reflex centre. The speaker thought one was justified in promising the patient more than one could accurately say was the whole truth; this was an important element in dealing with neurotic patients; but of course this practice might be abused. There were two sides to this question—

the " practical " and the " scientific," and while the exact sequence of cause and effect might be open to criticism from the scientific side, from the practical side there could be no doubt as to the propriety of nasal treatment in cases of asthma.

Dr. DUNDAS GRANT thought that Dr. Theodore Williams ought to have been more impressed by the result of the first case he mentioned, where nasal treatment had been of such great service and might with advantage have been carried out at a much earlier stage. Dr. Grant thought the discussion was too pessimistic on the one hand and too sanguine on the other, and that the truth was far from these extremes. He then related the history of a case in his early practice in east London. The patient was a chronic sufferer from bronchial asthma, and a very remunerative client. He urged the removal of nasal polypi importunately ; finally the man consented and was practically cured. He had seen the mere act of treating the nose for asthma make the condition for the moment worse though ultimately curing it. He had had a fair proportion of cases in which bronchial asthma had totally disappeared after nasal treatment. This was natural enough when one considered the class of cases likely to come into the hands of the nasal specialist. It was the duty of a physician, if treatment by drugs failed, to submit the case to the observation of someone accustomed to explore the nose, and capable of giving a reliable report as to whether or not an operation on the nose should be carried out. There should be a judicious combination of the medical and surgical treatments so as to give the patient a double chance of cure. Dr. Grant found the gouty diathesis well marked in a number of the cases which had been referred to him, an opinion confirmed by the beneficial effect of the administration of salicylate of soda, a drug which he thought might with advantage be more frequently employed in the treatment of asthma. The galvano-cautery in some cases acted beneficially by pinning down the turgescent mucous membrane, but its beneficial effect was often no doubt due to its action as a counter-irritant. After the application of the galvano-cautery he was in the habit of applying deliquescent trichloracetic acid, which appeared to him to diminish the inflammatory reaction. Antipyrin in a 4 per cent. spray reduced the swelling, but it was irritating and it ought therefore to be preceded by the application of eucain which acted, so far as anæsthesia was concerned, like cocain, and was in other respects freer from objection. Glycerine extract of supra-renal capsule applied in the form of a spray was often valuable as a vaso-constrictor.

Dr. CLIFFORD BEALE, in speaking of continued nasal treatment for asthma, described a case recently observed in which several operations had been performed from time to time until most of the interior of the nose had been removed. The attacks of asthma, relieved for a time after each operation, had regularly recurred. There was no evidence to show that the attacks arose from any sensitive point in the upper air-passages, whereas there were abundant morbid changes in the lower air-passages, which might equally well be assumed to be the starting point of a reflex spasm. In the heart, also, one might look for such causes. Some years ago he had a run of such cases. Four boys, all occupied in work that involved considerable heart strain, and all

about fourteen years of age, suffered from what appeared to be genuine asthmatic attacks, which were relieved by antispasmodic inhalations and rest. In these there was no reason to suspect any nasal reflex, but the attacks were far more likely to have found their origin in the over-strain of the immature heart. He quoted the observation of Dr. Moritz Schmidt to the effect that the nasal cavity if carefully searched with a probe might sometimes be found to present sensitive points, the irritation of which set up respiratory spasm. He thought that unless some definite evidence could be obtained that the source of irritation was in the nose, any operation except for the relief of obstruction was hardly justified.

Dr. WILLIAM HILL could not agree with the last speaker that it was "unjustifiable" to apply intra-nasal treatment unless a cough reflex was obtained; we had a plain duty to do the best we could for our patient, who rightly expected us to try not only every medical means, but also every surgical procedure which held out a reasonable chance of affording relief. A cure, in the strict sense of the word, could not, of course, be promised, nor often even expected, but a fair measure of relief, amounting in some instances to a practical cure, might, in his experience, be looked for in considerably more than half the cases where asthmatic symptoms were associated with obvious disease in the nose. If practitioners neglected intra-nasal treatment because they could not promise their patients an absolute cure, they not only ran the risk of being scored off by more enterprising neighbours, but, what was more serious, they laid themselves open to the charge of not having done their duty and their utmost for their patient. It was necessary to speak thus strongly because he feared that visitors at this debate, especially physicians who did not practice rhinology, would take away a very wrong impression of the attitude and experience of those who had dealt with a considerable number of cases of asthma with associated nasal disease. Not only was it necessary that a thorough examination of the nose should be made, in order that nothing abnormal might escape observation, but if intra-nasal treatment appeared to be indicated it was essential that this should be carried out in a very thorough way. Half measures were worse than useless, as they not only either failed to relieve at all, or led to early relapse, but unfortuately brought undeserved discredit on what was often a valuable remedial measure. He could not agree with Dr. Kidd's conclusions, but it was easy to understand difference of opinion here, as that physician, whose experience of asthma in general was large, frankly admitted that he had seen and treated very few cases indeed where there was a co-existing nasal factor. He desired to associate himself with the views of Dr. McBride, who had admirably summarised the scientific and clinical aspects of the subject, and whose practical suggestions on treatment all would do well to follow. Dr. Hill had not himself tried intra-nasal cauterisation where there was no obvious morbid condition in the nose, but he had made a note of what the opener of the discussion had said on that subject. In conclusion he thought he was considerably below the mark in asserting that marked relief might be expected in 50 per cent. of cases of asthma *plus* nasal disease, provided the nasal treatment was carried out with requisite

thoroughness; overlooking a small morbid area might make all the difference. He had no doubt it was our duty to advise our patients to submit to these surgical procedures, which were, after all, not formidable ones.

Sir FELIX SEMON, in a short historical retrospect, referred to the publication by the late Prof. Hack in 1884, entitled "Radical Cure of Hay Fever, Asthma, &c.," in which that author endeavoured to establish the existence of an intimate connection between affections of the nose and asthma. Long before that time, however, cases had been noted by good observers, such as Voltolini, Bernhard, Fraenkel and others, in which the mere removal of nasal polypi, not undertaken with any view to cure co-existing asthma, had been followed by that result, *i. e.* the asthma attacks—which had formerly been very troublesome, either entirely disappeared, or became less intense after the removal of the polypi—returned or became intensified with the recurrence of the polypi, and improved again after renewed removal. This was a very clear proof that asthma may be positively produced from the nose, and it was certainly a grave fault to altogether deny such a possibility. Nor were nasal polypi, although in the speaker's experience by far the most obvious, the only cause of nasal asthma; other forms of nasal obstruction could produce this effect, such as great tumefaction of the nasal mucous membrane, considerable deviation or excrescences from the septum, &c. In no class of cases, however, was the connection more clearly established than in cases of nasal polypi. In the speaker's experience, relief might be given by nasal treatment in such cases,—occasionally even when the asthma had been in existence for a long time, although the number of cases of the last-named category in which he had obtained satisfactory results was extremely small. Altogether the number of cases in which a short-lived success had been obtained was in his own experience infinitely greater than the number of those in which a long-lasting relief had been afforded. He himself had never been able to produce an asthmatic attack from the nose by exploring that cavity with the probe. In one single instance only had he been able to produce very violent paroxysmal cough by that method of investigation. With such experiences, he asked himself, what was one to tell a patient in whom asthma existed together with nasal disease? They had heard that afternoon diametrically opposed opinions in reply to that question. He invited them, however, to consider the enormous number of cases of asthma that had been treated since Hack's publication by intra-nasal interference. How small in proportion to these had been the number of those cases in which a real cure or, at any rate, a long-lasting improvement had been seen even by the warmest advocates of that treatment! In view of that fact, was one justified in promising any definite success to a patient? And what had struck him most in this discussion was that no mention had been made of those, in his experience most frequent cases, where *no results had been obtained at all!* Personally he divided these patients into three classes: (*a*) Lasting success obtained, exceedingly small percentage; (*b*) Temporary benefit, comparatively large percentage; (*c*) No success at all, very large percentage. Now considering that he had

to frankly confess that he was himself unable to make out beforehand, by any method of examination whatever to which of these three classes the individual patient would ultimately belong, what was the treatment in such cases but an "experimental" one? He stuck to this word most emphatically. He was in the habit of telling those patients suffering from asthma, in whom considerable nasal abnormalities existed: "Undoubtedly in a number of cases such as yours, in which the nose is treated, relief has been obtained; whether in your own case relief will be permanent or temporary, or whether there will be no relief at all, I cannot tell you beforehand. If your suffering are great, and if you should like to undergo this treatment, I consider your case a legitimate one for it, but you must understand that it is purely experimental." He had not found that his patients misunderstood so simple a statement.

Dr. StClair Thompson suggested the addition of a fourth class to Sir Felix Semon's classification, viz. those who were considerably damaged by the intra-nasal treatment. He had met these cases, who had suffered from a too forward policy of the nose and throat, at foreign health resorts, trying to get back their lost mucous membrane. He thought that in some cases of asthma the nasal conduction may be causal, but in many cases it was consequential.

Dr. Lambert Lack thought the undoubtedly frequent relation of asthma to nasal disease was not a simple reflex. He was very surprised to hear Dr. McBride's statement, on which he laid particular emphasis, that an irritant applied to the nasal mucosa may effect molecular changes in a centre which is responsible for asthma. In his experience he had never met with a single case in which irritation of the nose, as by probing, had produced an asthmatic attack, and he would much like to know if any other member had met with such a case. Dr. Thorowgood and others who supported this theory quoted instances in which cough had been produced. This Dr. Lack thought a not very uncommon result of nasal irritation, but he could not admit that a true asthmatic attack could be experimentally excited in such a way. He could add one case to those which had been cited, in which asthma was closely related to adenoid growths. The patient was a child, the subject of inherited asthma and gout. Removal of the adenoids was followed by complete freedom from asthmatic attacks; eighteen months later the asthma returned, and on examination there was found to be recurrence of the adenoids with nasal obstruction. Operation for the relief of the nasal obstruction was again followed by complete cessation of the asthma.

The President said they might be reasonably satisfied with the result of this discussion, which was of great interest; to a certain extent, the atmosphere was clarified. They had heard extreme views from both sides—those who thought no good was to be obtained, and those who believed that most benefit is derived from the adoption of intra-nasal treatment. Personally, he took the middle course, and he was quite certain that he had seen in a very fair proportion of the cases considerable and permanent relief; he mentioned the case of a lady whose polypi had been removed, and who had spent the winter in the Riviera, who had severe asthma, from which she had been

practically free for the last year. He thought they would all agree with the remark made by Goodhart that the "chronic asthmatic was almost as hard to cope with as the chronic epileptic," and they must not expect to work miracles or they would be disappointed. They should look to getting hold of the cases at an earlier stage, when relief is more easily given, especially in the case of adenoids.

Dr. PERCY KIDD said that his remarks had been misunderstood in some respects. He said that if there was obvious disease of the nose, local treatment was advisable, though the uncertainty of the result as regards the asthma should be clearly explained to the patient.

Dr. MCBRIDE said that owing to the kind reception his remarks had received, there was little left for him to reply to. With regard to the question of adenoids and asthma, he said that he had often seen cases where the patients were said to be asthmatic, but on inquiry it was generally found that the difficulty in breathing was due to the local causes. He had, however, on one occasion, as mentioned, immensely relieved a truly asthmatic child by removing adenoids. Questions had been asked as to the cure of asthma, but he considered that asthma, like epilepsy, could hardly be considered cured so long as the patient lived. He mentioned several cases illustrating the fact that asthma can be much benefited by local treatment of the nose, both in polypi and hypertrophic conditions. With regard to Dr. Beale's remarks, he begged to observe that he had never seen asthmatic paroxysms produced by touching the mucous membrane, but he would again refer to the great importance to be attached to the presence of a cough reflex in cases of suspected nasal asthma. With regard to Dr. Theodore Williams' remarks, Dr. McBride thought that they showed that laryngologists must be singularly devoid of the power of expressing their meaning clearly—it would not, of course, be proper to suggest another alternative. He failed altogether to see how Dr. Williams could have arrived at the conclusion that most of the speakers thought local treatment useless in asthma, and it would be a thousand pities that his remarks should be published as a serious contribution to the debate. Dr. McBride had no doubt that his words were spoken in jest, but every reader of the report might not be aware of this. With regard to Dr. Lambert Lack's criticism, he would refer him (1) to the fact that reflex nasal asthma was generally admitted to exist; (2) to the experiments of Lazarus which had been confirmed by Sandmann. It has thus been shown that irritation of the nasal mucous membrane can produce spasm of the bronchi and that such spasm ceases after section of the vagi.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

51ST ORDINARY MEETING, *June 2nd*, 1899.

F. DE HAVILLAND HALL, M.D., President, in the Chair.

WILLIAM HILL, M.D., }
LAMBERT LACK, M.D., } Secretaries.

Present—32 members and 5 visitors.

The minutes of the previous meeting were read and confirmed.

The following gentleman was unanimously elected a member of the Society:

Charles Heath, F.R.C.S., 3, Cavendish Place.

The following cases and specimens were shown:

CASE OF UNILATERAL PARALYSIS OF PALATE, PHARYNX, LARYNX, &C.

Shown by Dr. HERBERT TILLEY. The patient, a female æt. 29, had been complaining of hoarseness and dryness of throat with difficulty of swallowing for three months. There was an accumulation of saliva in the throat and some difficulty of swallowing solid food, and occasional regurgitation of fluids through the nose. Patient had probably had syphilis. Exami-

nation showed the left half of the soft palate, left half of the pharynx, and left vocal cord paralysed, the last being in the cadaveric position.

Sensibility was much diminished on the paralysed parts. The upper part of the left trapezius and the left sterno-mastoid showed unmistakable signs of commencing degeneration. There was no paralysis of the tongue or the facial muscles, and no evidence of any other cranial nerves being affected.

The exhibitor remarked that during the past four months he had met with four similar cases, and these tended to prove clinically, what Horsley and Rethi had shown experimentally, that it was the spinal accessory nerve which innervated the muscles of the larynx, the pharynx (partly), and the soft palate.

A Case of Disseminated Sclerosis with Paresis of Left Half of Soft Palate and Larynx, and a Case of General Paralysis with Paresis of Left Half of Larynx.

Shown by Dr. Jobson Horne.

Dr. Permewan asked what was meant by "general paralysis" in these cases. Did it mean "general loss of power"?

Sir Felix Semon would not have used the word "paralysis." A point of great interest in Dr. Horne's case was the nystagmus-like movements of the left vocal cord; abduction was separated into three distinct movements. He thought this a very interesting phenomenon, of which he was unable to give any elucidation; it might be a lesion below the fourth ventricle.

Dr. Jobson Horne said by general paralysis was meant general loss of power.

A Specimen of Larynx blocked by a Mass of Papillomatous Growth from a Boy aged Eleven.

Shown by Dr. Permewan. Six years ago, while the patient was under the care of Mr. Murray at the Liverpool Infirmary for Children, Dr. Permewan had seen him and removed some growths with the intra-laryngeal forceps. The dyspnœa still continuing, Mr. Murray performed thyrotomy, removed the

growths, and cauterised the base of them thoroughly. This was followed by much relief, but three years later the symptoms had recurred, and the operation was repeated, again with relief. In April of this year he was admitted into the Northern Hospital with evident signs of growths, but with no apparent urgency of symptoms; he was, however, found dead one morning, evidently from asphyxia. On post-mortem examination the larynx was found almost completely blocked by a large mass of papilloma as shown.

Dr. Permewan thought the point to be emphasised here was the fact that two complete thorough operations had failed to cure the case; he doubted whether thyrotomy was any more radical in its effects than the repeated removal by intra-laryngeal methods, difficult though that might be in young children.

The PRESIDENT suggested that a discussion might at some time be devoted to the treatment of these cases.

Dr. POWELL asked if tracheotomy was performed on this case.

Dr. PERMEWAN said that tracheotomy was done (before he had seen the patient) six years ago for urgent symptoms. The case showed too clearly the great tendency of these papillomatous growths to recur after complete removal. He thought it was better not to perform indiscriminate thyrotomy.

SPECIMEN OF LARYNX FROM A CASE OF PERICHONDRITIS.

Shown by Dr. PERMEWAN. The patient was admitted into the Liverpool Southern Hospital under Dr. Cameron in September, 1898, having been ill six weeks. There was then much cough and dyspnœa, which necessitated tracheotomy. The epiglottis and ary-epiglottic folds were much swollen, and the larynx externally measured $2\frac{3}{4}$ inches across. There were enlarged and painful glands on both sides of the neck, particularly the right side. The diagnosis lay between malignant disease and perichondritis of the thyroid cartilage; the lungs were healthy, but there was chronic bronchial catarrh. There were no tubercle bacilli in the sputum.

After some time the glands began to soften and break down; an abscess formed on the right side, and was opened, and bare cartilage found at the bottom of it. This was repeated two or

three times, and a small bit of cartilage came away. The laryngeal symptoms became less marked and more favourable, but six weeks before death he began to complain of pain in the lumbo-sacral region of spine. This was rapidly followed by angular curvature, followed by paraplegia, paralysis of the rectum, and bleeding, from which he died.

Larynx shows necrosis of thyroid cartilage, but no growth. No examination was made of the spine.

Case of Parathyroid Tumour causing Symptoms of Malignant Disease of the Larynx; Operation and Recovery.

Shown by Mr. de Santi. Patient, male æt. 58, sent to me by Mr. Eliot, who stated that he had been persistently hoarse for ten months, had a brassy cough and some stridor. Dr. Mitchell Bruce could find no chest affection to account for it. There was no pain or dysphagia, no expectoration, and no loss of flesh. Patient denied syphilis.

There was found very impaired mobility of right vocal cord and marked limitation in abduction. The right cord was uniformly red and somewhat swollen; there was no ulceration or neoplasm visible. No glands to be felt in the neck; old scarring of right face and cheek suggestive of old syphilis. Voice very hoarse and feeble. I considered it most probable that the case was one of early malignant disease of the larynx, with an alternative of syphilis or mediastinal tumour pressing on right recurrent laryngeal nerve. I ordered rest of voice, no smoking, and iodide of potassium.

In September, 1895, the patient's voice was almost a whisper. He had gone downhill rapidly, having lost much in weight. The right carotid artery pulsated visibly, and seemed pushed forward by a smallish, indefinite, probably glandular swelling deep in the neck, and about the level of second or third ring of trachea.

In December, 1895, the swelling in the neck was smaller, the voice better, the right vocal cord a little more moveable, and there was a gain in weight.

During 1896 the patient was in very fair health, had gained

weight; the voice, though hoarse, was stronger, and the swelling in neck moveable, softer, and more defined; the right vocal cord was *in statu quo*.

In February, 1899, patient had an attack of flatulence and dyspepsia; this was shortly followed by difficulty in swallowing solids, and later liquids. He lost flesh rapidly, half a stone between February 6th and March 29th. At the same time a very marked increase in the size of the cervical swelling was noted. There was regurgitation of food, and sensation of blockage at level of cricoid cartilage.

Examination of larynx showed right vocal cord more fixed, but otherwise the same. I passed a No. 18 œsophageal bougie, and met some considerable obstruction about level of upper part of sternum; no blood or pus on withdrawal.

The lump in the neck felt to be the size of a Tangerine orange. It seemed elastic, and not stony hard. I took a grave view of the case, and advised exploratory incision in the neck, as I considered from the whole course of the events that the main trouble was extra-laryngeal.

An incision was made over the anterior border of the right sterno-mastoid down to the level of the sternum and a large tumour exposed, situate in the lower carotid triangle, extending down to and under the upper part of the sternum. By careful dissection this tumour was gradually defined; I found it distinctly encapsuled, the carotid artery and jugular vein were pushed far over to the outer side: the whole tumour was very vascular. I eventually clearly isolated it, the chief difficulty being with the right recurrent nerve, which was attached to the tumour and flattened, and with the inferior thyroid artery; the right innominate and part of the left innominate vein were exposed, as the tumour was partly substernal. The œsophagus was seen to be distinctly compressed by the tumour; the latter had no connection with the thyroid gland, but there was some fibrous infiltration of the œsophagus opposite the seat of pressure.

A cross cut and partial division of the sterno-mastoid had to be made to thoroughly get at the tumour. The right dome of the pleura, the right phrenic nerve, and the right subclavian artery were seen at the time of operation.

Recovery was uneventful, and swallowing powers improved almost at once.

Microscopic sections show the tumour to be of the nature of parathyroid tissue and essentially innocent. The growth itself is completely encapsuled, and there is a large cyst in the centre.

The case seems to be of great interest. At first everything pointed to early malignant disease of the right vocal cord—the age of the patient, the uniform redness and impaired mobility of the cord, the hoarseness, and later the presence of a lump like a gland externally; on the other hand, time proved the trouble not to be intrinsic carcinoma. Later on, *i. e.* in February, 1899, everything again pointed to malignant disease, though more of the neck than the larynx.

Though the microscopic appearances are those of innocent tumour, I am still inclined to think that the tumour was commencing to become malignant, for the clinical course of sudden and rapid increase in activity in a man of sixty-two, of a tumour anywhere which may have remained dormant even for years, is always very suspicious, and I consider clinical evidence more important in such cases than microscopic evidence.

Case of Complete Paralysis of one Vocal Cord and Impaired Abduction of the other.

Shown by Dr. StClair Thomson. This patient, a boy æt. 17, was said to have been hoarse since his voice changed at the age of fourteen, and it was therefore to be presumed that the laryngeal condition had existed for three years. The condition is sufficiently described by the title of the case. There is nothing in the boy's neck, chest, or nervous system to explain the cause of the paralysis. The exhibitor suggested influenza as a possible cause, and wished to know if others had seen cases at this early age.

Dr. Permewan had had three cases of paralysis of the right vocal cord, of which he was not able to discover the cause; possibly it was due to disease of the top of the pleura. He did not agree with the other part of the title, viz. "impaired abduction of the other cord;" from his own view, it moved quite freely. Dr. StClair Thomson's suggestion of influenza ought to be taken into account. He had a

patient who suffered from influenza and had recurrent paralysis, which remained for some weeks. The patient then became convalescent and got well again.

Sir FELIX SEMON said he had seen several cases of laryngeal paralysis after influenza, amongst them those of two medical men who both got well in a short time. With regard to Dr. StClair Thomson's question as to the age of these cases, he had seen loss of abductor power in patients of one and a half to five years of age.

The PRESIDENT remembered seeing a case with Sir Felix Semon, which almost completely recovered; he had also reported to the Society a case of double abductor paralysis in a child of six.

Dr. STCLAIR THOMSON said he had shown a case undoubtedly due to influenza, which had cleared up between the announcement and the patient's appearance at the meeting, but in that case the patient had had the paralysis only six months, whereas in the case under notice the disease was of three years' standing.

CASE OF LARYNGEAL ULCERATION WITH CALCIFICATION OF THE FASCIA OF THE NECK.

Shown for Mr. CHARTERS SYMONDS by Mr. STEWARD. The patient, a woman æt. 32, complained of loss of voice and difficulty in breathing, and gave the following history.

When a child she had an abscess on the right side of the neck, and at about the same time she became deaf.

About ten years ago swelling and stiffness of the neck began, and this has gradually increased since that time.

The present attack of hoarseness commenced three months ago. The patient is very deaf, the skin is pallid, the bridge of the nose is broad and flattened. The eyes and teeth are normal. Just behind the angle of the jaw on the right side is a large scar. The whole of the structures in the front of the neck are hard and matted. There is great thickening around the hyoid bone and thyroid and cricoid cartilages, and these structures appear to be united into a dense hard mass.

There are several enlarged glands in the submaxillary region, and lower down in the neck are several very hard nodules, one particularly hard being situated in the right sterno-mastoid muscle. The soft palate and pharynx are much scarred, and are adherent to one another.

The upper opening of the larynx is red and swollen, and there is ulceration on the right ventricular band.

Sir FELIX SEMON said that he had a strong suspicion that this case was specific. The configuration of the patient's face and the large distance between the eyes pointed to congenital syphilis. With regard to the pharynx, the adhesions are very characteristic of either tertiary or inherited syphilis.

Dr. WILLIAM HILL said that Mr. Symonds was doubtful as to the correctness of the term "calcification." To him it seemed to be an extensive line of scars rather than calcification.

Mr. STEWARD said that the whole thing might be syphilitic. There was considerable swelling on the right side of the larynx, loss of voice, and troublesome dyspnœa, which was steadily getting worse in spite of calomel baths and doses of iodide of potassium for three weeks.

CASE OF SLOUGHING ULCERATION OF THE PHARYNX.

Shown by Mr. STEWARD for Mr. CHARTERS SYMONDS. Male æt. 31, has always been healthy till nine months ago; has no history of syphilis.

At the end of October, 1898, patient had a thick discharge from the nose, with headache and pains in the back. Shortly after this a hard round lump appeared below the left ear, and a similar lump soon appeared on the right side. These were followed by other lumps, which coalesced to form large swellings. Later the tonsils were enlarged, and a large ulcer with yellow surface appeared on the left one, and soon afterwards the right tonsil became similarly affected. The left tonsil healed, but the swellings in the neck steadily increased.

When first seen on December 11th, 1898, there was a large ulcer involving the lower part of the right tonsil, and extending on to the base of the tongue. The ulcer was covered with yellow slough, and the edge was hard, raised, and indurated. There were also large masses of swollen glands on each side of the neck; some of these were soft and fluctuating, others quite hard.

Patient was ordered iodide of potassium in increasing doses, and for a time improved.

On March 9th the ulcerations had considerably increased, as had also the swellings in the neck. Small hard glands were found in the left axilla and right groin. Calomel vapour-baths were ordered in addition to the potassium iodide, and on March

14th the ulcers were curetted, and then cauterised with nitric acid.

After this considerable improvement took place and the throat nearly healed, but early in May a relapse occurred, and spread of ulceration took place.

On the 9th several softening glands were opened and curetted, and one was removed; the throat was also again curetted.

The softened glands contained a semi-fluid material of yellowish-brown colour. Microscopically the excised gland showed caseating foci and a small-celled infiltration, but no definite evidence of tubercle.

Mr. CRESSWELL BABER said that in his opinion the case was syphilitic.

Sir FELIX SEMON thought there was little doubt it was a case of lympho-sarcoma, and advised the administration of arsenic. He had seen three or four such cases in which tumours had formed and disappeared almost entirely; suddenly they would appear again and assume a serious form. He always treated them by increasingly big doses of arsenic.

Mr. STEWARD said the man had been treated with large doses of iodide and mercury, but had not had arsenic. It might be of interest to mention that the man had several glands in the right axilla and in the left groin. As regards the examination of the stuff from the opening in the neck and gland, the view of lympho-sarcoma was supported. Under the microscope was seen a mass of small round cells, with fair-sized nuclei, and there were caseous foci in the gland itself. No tubercle bacilli were found.

Dr. WILLIAM HILL thought if the suggested arsenic treatment was of no avail it would be well to try electrolysis.

TUMOUR OF THE NASAL CAVITY.

Patient and specimen shown by Mr. CRESSWELL BABER. A female æt. 66 came as out-patient on March 17th last, complaining of right nasal obstruction since the previous summer. She had also had a sore throat and pain in the right ear. No deafness. A large polypus was snared from the right nostril. On April 7th a polypus was felt in the right choana with the finger, and snared from the front. April 14th.—Right side still much obstructed, also much muco-purulent discharge. Posterior rhinoscopy, with the aid of the palate-hook, showed a red

growth in the right choana; two more pieces of reddish, friable growth snared from the front. May 1st.—On palpation, a small mammillated moveable growth was felt in the right posterior naris. May 2nd.—The growth could be just discerned from the front, and was moveable, but whether it grew from the inferior turbinated body, or from the outer wall of the nasal cavity, could not be ascertained—it was not attached to the septum. Transillumination on April 21st and May 2nd showed both infra-orbital regions light. No enlarged glands.

The growth removed on April 14th was reported on by the Clinical Research Association as "columnar-celled carcinoma arising from the nasal mucous membrane." I decided to take steps to lay the disease freely bare, so that its extent could be more clearly seen, and, if necessary, a radical operation performed. With this object, on May 6th I removed, under general anæsthesia, the growth in the posterior naris with the spoke-shave, and subsequently the inferior turbinated body with the same instrument. The outer wall of the nasal cavity was then freely curetted with a large sharp spoon. Afterwards, on inserting the little finger into the nasal cavity, I could feel that there was an aperture into the antrum, probably the result of the curetting. The growth was soft and irregular. The patient recovered from this well, and has been kept carefully under observation.

Her present condition—more than three weeks after the operation—is as follows:—There is some dirty-looking, fœtid, muco-purulent discharge coming from the right nasal cavity. In consequence of the removal of the inferior turbinated body the nasal cavity can be easily inspected. The only sign of the growth is what looks like small, rather vascular roots of mucous polypi, between the lower margin of the middle turbinated body and the outer wall. No growth seen by posterior rhinoscopy, though there is a red spot on the margin of the right choana at its upper outer part, where the last growth may have sprung from. Still plunging pain in the right ear. Both antra light up on transillumination, but the right seems a shade darker than the left. Possibly some of the discharge may have got into the antrum.

Mr. Baber asked the opinion of members as to the malignancy

of the growth, and the advisability of further operative measures.

Dr. PEGLER thought that the growth was not malignant; one corner of the slide showed doubtful-looking cells, but not characteristic of carcinoma. He suggested the specimen should be referred to the Morbid Growths Committee.

Dr. WILLIAM HILL asked whether it was ulcerated on the surface, and if there was any hæmorrhage before operation. It was not possible to make a diagnosis, as the sections did not go to the root of the tumour.

Mr. BABER said Mr. Butlin had seen them, and thought the case was one of carcinoma.

Dr. WAGGETT said it would be a valuable section to have in the cabinet for reference in subsequent years.

Mr. BABER said he would do no further operation unless there was a recurrence.

The PRESIDENT moved that the specimen be referred to the Morbid Growths Committee. This was adopted.

SPECIMEN OF EPITHELIOMA OF ŒSOPHAGUS CAUSING BILATERAL PARALYSIS OF VOCAL CORDS.

Shown by Dr. CLIFFORD BEALE. L. H—, æt. 33, female domestic servant, admitted January 13th, 1899, for cough and muco-purulent expectoration of long standing, with some dysphagia and occasional dyspnœa. The patient was a good deal emaciated, and complained of recent acute tenderness of the left side of the thyroid. Some swelling and tenderness was present. On examining the larynx the vocal cords were seen to be normal in appearance, but lay during normal and forced respiration in the cadaveric position. On phonation they were brought together, and a fair volume of sound was produced. While under observation in hospital many attacks of adductor spasm occurred, and the voice gradually got feebler until it was lost altogether. The sensation within the larynx was unimpaired. Tracheotomy became necessary and gave immediate relief. Dysphagia increased especially for solid food, and it was noted that fluids and sometimes solids were occasionally regurgitated through the tracheotomy tube; and hence, after a short period of rectal feeding, gastrostomy was performed, and the patient was fed directly into the stomach for the five weeks pre-

ceding her death. The constant welling up of muco-pus from the œsophagus, and the occasional regurgitation of the food in the stomach, led by slow degrees to a septic broncho-pneumonia, which was the immediate cause of death on April 12th, 1899.

The specimen showed infiltration of the mucous membrane and submucous tissue of the œsophagus by a cancerous growth. The growth began below the level of the larynx, and extended for about two and a half inches downwards, embracing the whole lumen of the tube. At the anterior part a perforation communicating with the trachea was visible. The œsophagus above and below the growth was healthy though somewhat engorged. The thyroid body was enlarged and thickened in both lobes, being exceedingly tough and fibrous on section. The trunk of the vagus was seen to be compressed, together with the vessels, on one side, while the recurrent laryngeal nerve could be traced into the body of the thickened thyroid gland on the other side. No other cancerous growth was discovered in any part. The growth in the œsophagus was a typical epithelioma.

Case of Unusual Pharyngeal Tumour.

Shown by Sir Felix Semon. The patient, a female, was shown at the March, 1898, meeting of the Society, and was now again brought forward to show that the condition remained absolutely *in statu quo.*

Dr. William Hill asked Sir Felix Semon to explain why he took such pride in keeping this tumour.

Sir Felix Semon had the greatest pleasure in answering that question; he did not feel justified in doing anything because he did not know what the growth was or how far it went. That it was intimately connected with the vagus he suspected because the least pressure caused coughing and retching; meanwhile it caused the patient no inconvenience whatever.

A Case of Stricture of the Larynx following Tracheotomy for Diphtheria successfully treated by Dilatation.

Shown by Dr. Lambert Lack. The patient, a child æt. 6, had

tracheotomy performed for diphtheria one year ago. Three months later, it being impossible to remove the tube, an exploratory thyrotomy was performed by Mr. Stanley Boyd, and an ulcer of the larnyx with much granulation tissue, almost completely obstructing the lumen, was found just below the vocal cords. The granulation tissue was removed and the wound allowed to heal. Attempts were then made to dilate the stricture of the larynx by intubating with O'Dwyer's tubes; but after a month of intermittent treatment this method was abandoned, its tediousness and painfulness seriously affecting the child's health. It was then resolved to dilate the stricture from below. A metal plug with a shield attached to fit over the tracheotomy tube was made. Under chloroform the tracheotomy wound was enlarged and the stricture forcibly dilated with curved forceps; the plug and the tracheotomy tube were then inserted. The plug was worn continuously for five months without causing any inconvenience; it was then removed, and the tracheotomy tube was corked up. The child being able to breathe freely through the mouth both day and night, after a month the tube was dispensed with. The wound soon healed, and the patient now—a month later—seems cured.

The PRESIDENT congratulated Dr. Lack on his success in this case. Many attempts had been made and much time had been spent in trying to dilate laryngeal strictures, but generally in vain.

Dr. LACK, in replying to a question by Dr. Permewan, said that the dilatation was done through the tracheotomy wound with ordinary dilators and a plug inserted to keep the parts dilated, and worn for about five months continuously. He had treated the case with intubation tubes, but directly they were left out the trouble recurred.

CASE OF NODE IN NASAL PROCESS OF THE RIGHT INFERIOR MAXILLA AND ULCERATIVE RHINITIS IN A TUBERCULAR GIRL.

Shown by Mr. ATWOOD THORNE. The patient, a girl æt. 7, came to St. Mary's Hospital complaining that for the last two months the nose had been gradually growing broader, and the nostrils becoming increasingly blocked. The trouble was attributed to a fall on the nose.

On examination there was found a mass as large as a hazel-nut attached to the nasal process of the right superior maxilla, and there was some swelling in a similar position on the left side. The nostrils were almost completely blocked by pale granular masses, and there was a thin watery discharge.

With the exception of a very small opacity of the left cornea (said to be due to an accident) there was nothing to suggest congenital syphilis, while the patient had been in St. Mary's for the treatment of a tubercular ulcer of the foot, and had had an operation at Golden Square for enlarged cervical glands.

The PRESIDENT asked if the nasal secretion had been examined for tubercle bacilli.

Dr. HILL suggested the case was a mixture of syphilis and tubercle.

CASE OF TUMOUR OF PALATE IN WOMAN ÆT. 34.

Shown by Dr. BOND. The swelling was first noticed twelve years ago shortly after the extraction of three teeth. It slowly increased in size, but lately has grown more rapidly. There is now an elastic, painless, non-tender swelling covering the hard palate, and extending into the alveolus on the right, and also into the soft palate. It is rather more dusky than the normal mucous membrane; in the centre is a paler area. There are no enlarged glands in the neck. The floor of the nose is normal.

The growth was thought by several members to be an adenoma. Dr. Bond proposed to report further on the case after operation.

Mr. DE SANTI took the swelling of the palate to be an adenoma, and considered it would be quite an easy matter to dissect it out.

Dr. WATSON WILLIAMS said that many years ago one of the first cases he saw in a young girl about fourteen was very similar to this. The tumour had existed for some years, and was increasing in size very greatly. It contained numerous small cysts. He had opened the growth and introduced weak chromic acid, with the result that the growth was inflamed for some days and soon after disappeared entirely, and it had not recurred a few years later.

Dr. BOND said he proposed attempting to remove the growth in a few days.

Female æt. 26, with Large Sarcomatous Tumour of the Naso-pharynx.

Shown by Dr. StClair Thomson. Though not by any means rare in early life, this case was shown as an example of malignant disease in a young adult. The patient had traces of having been operated upon for tuberculous glands in the neck, and it was therefore a little difficult to say whether the glands, which were now evident on each side of the neck, were also tuberculous, or whether they were secondary to the malignant growth. They were sufficiently hard. The growth pushed forward the soft and hard palates without invading them. It completely obstructed the choanæ, and had seriously interfered with swallowing and breathing. The author invited discussion as to whether an attempt should be made to remove the growth, and as to whether the patient should have tracheotomy or gastrostomy or both.

Mr. de Santi looked upon this swelling as probably of a malignant nature; its rapid growth and general appearance were consistent with such a diagnosis. The glands, though originally the patient had had tubercular cervical glands removed, were probably sarcomatous. Though the case might be one of mixed infection, tracheotomy should be done soon, and then an attempt to explore the palatal growth might be made. It would be interesting to know the microscopic appearances.

Dr. Bond thought that tracheotomy ought to be done; then it would be possible to get away some of the mass from the mouth: a large part might be snared off. In any case after tracheotomy, it should be thoroughly examined with the finger. He thought something might be done to relieve the case for a time.

Dr. Tilley asked if the glands were secondary to the particular growth in the palate or independent.

Dr. StClair Thomson was encouraged to follow the advice given. The woman had had tubercular glands in the past, and he thought they were not secondary to this growth.

A Case of Laryngeal Disease for Diagnosis.

Shown by Mr. E. W. Roughton. A man æt. 42, suffering from hoarseness, cough, and dyspnœa of three months' duration.

There was a swelling involving and fixing the left cord and arytænoid. No evidence of tuberculosis and no history of syphilis. He asked for a diagnosis.

Mr. DE SANTI was of opinion that this was a case of epithelioma. There was marked infiltration of the parts and very impaired mobility. Moreover the redness was quite unilateral, and fulness could be seen below the cord. An early laryngo-fissure was urgently needed.

Dr. WILLIAM HILL said he was inclined to think it was malignant. There were no glands on the outside; it was the sort of case well suited for an exploratory thyrotomy.

Sir FELIX SEMON suggested removing a piece first.

Dr. STCLAIR THOMSON said the cord was quite fixed, and the growth extended below the cord. He thought it a good case for laryngo-fissure.

The general opinion of members was that the case was very suitable for exploratory thyrotomy.

CASE OF MALFORMATION OF PALATO-PHARYNGEI MUSCLES.

Shown by Dr. FITZGERALD POWELL. A man æt. 22 presented himself for treatment at the hospital, suffering from suppuration of the middle ear, with hypertrophic rhinitis. This condition followed scarlet fever fourteen years previously.

On looking into his pharynx it was seen that the palato-pharyngei muscles forming the posterior pillars of the fauces on both sides, instead of passing down in the normal position, were drawn backwards and united together, leaving a small opening below the uvula into the post-nasal space.

The united muscles spread out over the posterior wall of the pharynx and became attached to it for some distance, when they parted and fell away in crescentic folds to their attachment to the posterior border of the thyroid cartilage.

The appearance on examination conveyed the impression that this condition was caused by extensive ulceration, and the history of severe scarlet fever deepened this impression, though on further and more prolonged inspection doubts arose as to whether this malformation was not due to congenital mal-development, the condition was so very symmetrical.

Mr. BABER thought it was the result of an ulceration, secondary to scarlatina rather than congenital. In the first year of this Society he

had shown a similar case. He was not sure whether it was from scarlet fever.

The PRESIDENT had seen almost the same thing. He thought a deep ulceration, if in the centre, would cause that symmetry.

A CASE OF EPITHELIOMA OF THE PHARYNX.

Shown by Mr. ATWOOD THORNE for Dr. DUNDAS GRANT. The patient, a clerk æt. 58, came to the hospital on May 25th complaining that for two months he had had increasing pain on swallowing. He had also been losing flesh somewhat for about the same period.

On examination there is seen a craggy mass on the right side of the pharynx, extending to the base of the tongue on the same side. With the finger the mass is found to be of almost cartilaginous hardness. There is marked involvement of the glands on the right side of the neck.

The case was shown especially for the consideration of the advisability of operation.

A CASE OF PACHYDERMOID LARYNGITIS TREATED WITH SALICYLIC ACID.

Shown by Dr. DUNDAS GRANT (per Mr. ATWOOD THORNE). The patient, a man æt. 56, "chucker-out" at a music hall, came to the hospital at the beginning of April complaining of a "husky voice."

The cords were partially concealed by very swollen ventricular bands; they were obviously less tense than normal, and on their edges there was what looked like a layer of desquamating epithelium. The rest of the cords was red and succulent, and in the interarytænoid space the mucous membrane was swollen and sodden-looking. The nasal mucous membrane was in general hypertrophied, and there was a considerable excess of mucous secretion.

The patient was advised to give up all alcoholic drinks (in which he usually indulged somewhat freely), and twice a week, in gradually increasing strength, an alcoholic solution of sali-

cylic acid has been applied to the thickening in the larynx. At the same time he has been ordered an alkaline lotion to wash out his nose. He has now quite regained his voice, and though the swelling has not altogether disappeared, the whitish thickening on the edges of the cords is hardly perceptible.

Case of Bilateral Abductor Paralysis, &c.

Shown by Mr. Richard Lake. The patient is a man, and has suffered from cough and dyspnœa for three months; now both cords seem fixed in the cadaveric position: there is a breaking-down gumma of the right tonsil. There is slight ptosis of the left eye, the left pupil is large and inactive, there is paralysis of all the recti muscles and of the inferior oblique. Under iodide the conditions have improved.

A case of pachydermia laryngis in a tubercular patient was also shown by Mr. Lake.

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1899 POWELL, H. FITZGERALD, M.D., F.R.C.S.Ed., 7, Connaught street, Hyde park, W.

1897 RAMSAY, HERBERT, F.R.C.S., 35A, Hertford street, Mayfair, W.

O.M. REES, JOHN MILSOM, F.R.C.S.Ed., 53, Devonshire street, Portland place, W.

1898 ROBINSON, H. B., M.S., F.R.C.S., 1, Upper Wimpole street, W.

1894 *ROUGHTON, EDMUND, M.D., B.S., F.R.C.S., 38, Queen Anne street, W.

Elected.

1893 SANTI, PHILIP ROBERT WILLIAM DE, M.B., F.R.C.S., 42, Harley street, Cavendish square, W.

1896 SCHORSTEIN, GUSTAVE, M.B., F.R.C.P., 11, Portland place, W.

O.M. *SEMON, SIR FELIX, M.D., F.R.C.P., 39, Wimpole street, W. *P. V.-P. C.*

1894 SHARMAN, HENRY, M.D., 16, Frognal, Hampstead.

1893 SPENCER, WALTER GEORGE, M.S., F.R.C.S., 35, Brook street, Grosvenor square, W. *C.*

1898 SPICER, FREDK., M.D., 57, Devonshire street, W.

O.M. SPICER, SCANES, M.D., 28, Welbeck street, Cavendish square, W. *S. C. V.-P.*

1895 STEPHEN, G. CALDWELL, M.D., 54, Evelyn gardens, South Kensington.

1898 STEWARD, FRANCIS J., M.S., F.R.C.S., 24, St. Thomas's street, S.E.

O.M. STEWART, WILLIAM ROBERT HENRY, F.R.C.S.Ed., 42, Devonshire street, Portland place, W. *S. C. V.-P.*

O.M. *SYMONDS, CHARTERS JAMES, M.S., F.R.C.S., 26, Weymouth street, Portland place, W. *C. V.-P.*

1894 *THOMSON, STCLAIR, M.D., 28, Queen Anne street, Cavendish square, W. *S. C.*

1896 *THORNE, ATWOOD, M.B., 10, Nottingham place, W.

1893 TILLEY, HERBERT, M.D., B.S., F.R.C.S., 101, Harley street, W. *S. C.*

1893 WAGGETT, ERNEST BLECHYNDEN, M.B., 45, Upper Brook street, Grosvenor square, W. *S.*

O.M. WALSHAM, WILLIAM JOHNSON, M.B., F.R.C.S., 77, Harley street, W. *T.*

1896 WHAIT, J. R., M.D., C.M., Charltons, Fairhazel gardens, South Hampstead.

O.M. WHISTLER, WILLIAM MACNEILL, M.D., M.R.C.P., 18, Wimpole street, W. *V.-P. C.*

1893 WHITE, WILLIAM HALE, M.D., F.R.C.P., 65, Harley street, W.

O.M. WILLCOCKS, FREDERICK, M.D., F.R.C.P., 14, Mandeville place, Manchester square, W.

O.M. *WILLS, WILLIAM ALFRED, M.D., M.R.C.P., 29, Lower Seymour street, W.

Elected.

1897 *Wingrave, V. H. Wyatt, M.R.C.S., 11, Devonshire street, W.

1897 Yearsley, P. Macleod, F.R.C.S., 33, Weymouth street, W.

COUNTRY.

The names of Country Members who have paid a "Compounding" Fee are printed in heavier type.

Elected.

O.M. Baber, Edward Cresswell, M.B., 46, Brunswick square, Brighton. *C. V.-P.*

†1895 Bark, John, F.R.C.S.Ed., M.R.C.P.I., 54, Rodney street, Liverpool.

1895 Baron, Barclay J., M.B., 16, Whiteladies road, Clifton. *C.*

1897 Bean, C. E., F.R.C.S., 19, Lockyer street, Plymouth.

O.M. Bennett, Frederick William, M.D., 25, London road, Leicester. *C.*

1895 Brady, Andrew John, 3, Lyons terrace, Hyde park, Sydney, New South Wales.

O.M. Bronner, Adolph, M.D., 33, Manor row, and 8, Mount Royd, Bradford. *C. V.-P.*

1894 Brown, Alfred, M.D., Sandycroft, Higher Broughton, Manchester.

1898 Burt, Albert H., Throat and Ear Hospital, Brighton.

1893 Charsley, Robert Stephen, The Barn, Slough, Bucks.

1898 Claremont, Claude C., M.D., B.S., 57, Elm grove, Southsea.

1893 **Davison, James**, M.D., M.R.C.P., Streate place, Bath road, Bournemouth.

1895 Downie, J. Walker, M.B., 4, Woodside crescent, Glasgow.

1893 *Embleton, Dennis Cawood, M.D., St. Wilfrid's, St. Michael's road, Bournemouth.

1893 Foster, Michael, M.B., Villa Annita, San Remo.

1898 Foxcroft, F. W., M.B., 33, Paradise street, Birmingham.

1898 Frazer, Wm., Johannesberg, South Africa.

Elected.

1900 HAYES, GEORGE CONSTABLE, F.R.C.S., 22, Park Place, Leeds.

1897 HERDMAN, RONALD T., M.B., C.M., Gwélo, Rhodesia, South Africa.

O.M. HODGKINSON, ALEXANDER, M.B., 18, St. John street, Manchester. *V.-P.*

1894 HUNT, JOHN MIDDLEMASS, M.B., C.M., 55, Rodney street, Liverpool.

1898 HUTCHISON, A. J., M.B., 225, Bath street, Glasgow.

O.M. JOHNSTON, ROBERT MCKENZIE, M.D., F.R.C.S.Ed., 2, Drumsheugh gardens, Edinburgh. *C.*

1898 KELLY, A. BROWN, M.B., C.M., 26, Blythswood square, Glasgow.

1895 LINDSAY, DAVID MOORE, 373, Main street, Salt Lake City, Utah Territory, U.S.A.

1895 MACINTYRE, JOHN, M.B., C.M., 179, Bath street, Glasgow.

1894 MACKERN, GEORGE, M.D., Club Estrangeros, Calle Vittoria 536, Buenos Ayres, Argentina.

O.M. *MCBRIDE, PETER, M.D., F.R.C.S.Ed., 16, Chester street, Edinburgh. *V.-P.*

1898 MARSH, F., F.R.C.S., 34, Paradise street, Birmingham.

1893 MILLIGAN, WILLIAM, M.D., 28, St. John street, Manchester. *C.*

O.M. NEWMAN, DAVID, M.D., 18, Woodside place, Glasgow. *C.*

O.M. *PARKER, CHARLES ARTHUR, F.R.C.S.Ed., High street, Rickmansworth, Herts.

O.M. PATERSON, DONALD ROSE, M.D., M.R.C.P., 18, Windsor place, Cardiff.

1893 PERMEWAN, WILLIAM, M.D., F.R.C.S., 7, Rodney street, Liverpool.

1899 REID, ST. GEORGE CAULFIELD, Thornton Heath, Croydon.

1895 REYNOLDS, ARTHUR R., M.D., 36, Washington street, Chicago, U.S.A.

1895 *RIDLEY, W., F.R.C.S., Ellison place, Newcastle.

1895 *SANDFORD, ARTHUR W., M.D., M.Ch., 13, St. Patrick's place, Cork, Ireland.

1898 SCATLIFF, J., M.D., 11, Charlotte street, Brighton.

1897 SENDZIAK, Dr. JOHANN, 139, Marszatkowska-Strasse, Warsaw, Russian Poland.

Elected.

1898 SNELL, SYDNEY, M.D., 2, Pavilion square, Scarborough.

1896 TOMSON, W. BOLTON, M.D., Park street West, Luton, Beds.

1896 TURNER, A. LOGAN, M.D., F.R.C.S.Ed., 20, Coates crescent, Edinburgh.

1895 VINCENT, GEORGE FOURQUEMIN, Hallaton, Leicestershire.

1897 WALKER, HENRY SECKER, F.R.C.S., 45, Park square, Leeds.

O.M. WALKER, THOMAS JAMES, M.D., 33, Westgate, Peterborough. *V.-P.*

1895 *WARNER, PERCY, Woodford.

1900 WESTMACOTT, FREDERIC H., F.R.C.S., 8, St. John street, Manchester.

1893 **WILLIAMS, PATRICK WATSON**, M.D., 2, Lansdowne place, Victoria square, Clifton, Bristol. *C.*

LIST OF EXCHANGES.

PERIODICALS:

The Journal of Laryngology, Rhinology, and Otology (London)
The Laryngoscope (St. Louis, U.S.A.).
Annales des Maladies de l'Oreille, &c. (Paris).
Revue de Laryngologie, &c. (Bordeaux).
Centralblatt für Laryngologie.
Archiv für Laryngologie (Berlin).
Monatsschrift für Ohrenheilkunde, &c.
Archivio Italiano di Otologia (Turin).
Bollettino delle Malattie dell' Orecchio, &c. (Florence).
Archivii Italiani di Laringologia (Naples).
Archives Internationales de Laryngologie, Otologie, et Rhinologie (Paris).

TRANSACTIONS OF THE FOLLOWING SOCIETIES:

British Laryngological, Rhinological, and Otological Association.
American Laryngological Association.
American Laryngological, Rhinological, and Otological Society.
Gesellschaft der Ungarischen Ohren- und Kehlkopfärzte.
New York Academy of Medicine, Section of Laryngology.
Wiener Laryngologische Gesellschaft.
Niederländische Gesellschaft für Hals-, Nasen-, und Ohrenheilkunde.